CAROLINA CARDIOLOGY ASSOCIATES

Name: _____ Date of Birth: _____

Race: _____ Male / Female Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ Cell: _____

Family Physician: _____

Referring Physician: _____

How Did you hear about us?

o Referring Doctor o Newspaper o Family Friend

o Social Media o TV/Radio o Health Fair

o Internet o Yellow Pages o Billboard

o Other _____

Primary Insurance _____

Secondary Insurance _____

Do you have Veteran Health Benefits? O Yes O No

Have you been seen in the hospital or ER recently? O Yes O No

If so, at which hospital were you seen? _____

Emergency Contacts:

Name: Phone Number:

_____

_____

I hereby authorize payment of medical benefits directly to Carolina Cardiology Associates, P.A., if any, otherwise Payable by me for services rendered on my behalf. I also authorize Carolina Cardiology Associates, P.A. to release medical information to process insurance claims and to other physicians, hospitals, or other healthcare institutions to aid in medical treatment. This authorization applies to all occasions of service until revoked. I attest that the above information is correct and complete to the best of my knowledge.

Signature: _____ Date: _____