Patient Information Form

Doctor: ___________________________

ALL INFORMATION MUST BE FILLED OUT COMPLETELY

Name: ____ Date of Birth: __________________________

Social Security #: ____ Male: ________ Female: ________

Address: ____
(NUMBER AND STREET) (CITY) (STATE) (ZIP)

Home Phone: _________________________________ Best contact phone #:_______________________________

Emergency Contact: _________________________ Phone #:______________________ Relation: ____________

Cardiologist:____ Phone#:_________________________________

Primary Care Physician: ____________________________________ Phone #:______________________________

Employer/Occupation: _________________________________ Phone #: _________________________________

Primary Insurance: ____ ID #: ______________________________

Group #: ____________________ Insured's Name: __________________________ DOB: __________________

Insured's Employer: ____

Secondary Insurance: ____ ID #: _____________________________

Group #: ____________________ Insured's Name: __________________________ DOB: __________________

Insured's Employer: ____

Authorization to release information: I hereby authorize Southwest Heart and Lung, pc to release any information required in the course of my examination or treatment which shall include HIV, communicable disease or drug abuse information.

Authorization to pay: I hereby authorize payment directly to the business of Southwest Heart and Lung, pc for the surgical and or medical benefits if any, otherwise payable to me for the services. I understand that I am financially responsible for the charges not covered by my insurance.

PATIENT SIGNATURE: ____ DATE: ___________________