PATIENT INFORMATION — PLEASE PRINT

Name of Patient:		Date:
Home Address:		Home Telephone:
City:	State:	Zip:
Work Phone:	Cellular Phone:	E-Mail:
Date of Birth:	Sex: ❑ Male ❑ Female	
❑ Single ❑ Married ❑ Widowed ❑ Divorced	Social Security Number:	
If Married - Name of Spouse:		
If Minor - Name of Parents:		
Person Financially Responsible for Patient:		Relationship:
Emergency Contact:	Relationship:	Telephone:
Referring Physician:		HIPAA ❑ Read ❑ Signed
Referring Physician Address:		

PRIMARY INSURANCE

Name of Insured:	Relationship to Patient:
Address (if different than patient):	
Insured's Date of Birth:	Social Security Number:
Insured's Employer:	Work Telephone:
Insurance Plan Name:	
Policy Number:	Group Number:
Co-Pay:	Deductible:
Type of Plan: ❑ BC/BS ❑ Medicare ❑ HMO ❑ PPO ❑ Commercial	

SECONDARY INSURANCE

Name of Insured:	Relationship to Patient:
Address (if different than patient):	
Insured's Date of Birth:	Social Security Number:
Insured's Employer:	Work Telephone:
Insurance Plan Name:	
Policy Number:	Group Number:
Co-Pay:	Deductible:
Type of Plan: ❑ BC/BS ❑ Medicare ❑ HMO ❑ PPO ❑ Commercial	

ASSIGNMENT OF MEDICARE BENEFITS

I request that my payment of authorized Medicare benefits be made to me or on my behalf to Downriver Cardiology Consultants, P.C. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it.

Signed _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY

I hereby understand that I am fully responsible for any and all "allowed amount" or "lack of referral" fees which my insurance company may or may not pay. I hereby acknowledge that I have been fully informed and competely understand my potential financial responsibilities.

Signed _____ Date: _____