



**PATIENT INFORMATION**

Patient's Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  Female  Male

Marital Status:  Married  Widowed  Single  Minor  Separated  Divorced  Other

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Patient Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer/School Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Who may we contact in case of an emergency? \_\_\_\_\_  
Name Telephone Relationship to Patient

Whom may we thank for referring you? \_\_\_\_\_

Are you here for preoperative clearance? \_\_\_\_\_

What type of surgery will you be having? \_\_\_\_\_

What date is your surgery scheduled for? \_\_\_\_\_

**Please note that you must notify our office immediately if your surgery date changes during the course of your cardiology work-up.**

**GUARANTOR INFORMATION**

SAME AS PATIENT  IF OTHER, PLEASE COMPLETE THE FOLLOWING:

Guarantor's Full Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  Female  Male

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Guarantor's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**INSURANCE INFORMATION**

POLICY SUBSCRIBER:  SAME AS PATIENT  SAME AS GUARANTOR  IF OTHER, PLEASE COMPLETE THE FOLLOWING:

Subscriber's Full Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  Female  Male

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**ADDITIONAL INSURANCE INFORMATION**

IS PATIENT COVERED BY ADDITIONAL INSURANCE?  YES  NO

POLICY SUBSCRIBER:  SAME AS PATIENT  SAME AS GUARANTOR  IF OTHER, PLEASE COMPLETE THE FOLLOWING:

Subscriber's Full Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  Female  Male

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_



Subscriber's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Pinnacle Cardiology, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I hereby authorize that the above-named provider may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services during the course of my treatment.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient, Parent, Guardian or Personal Representative