Resp Provider: ______ **Patient Profile** Patient Balance:

PATIENT INFORMATION

Name:

Preferred:

Patient ID #:

Sex: [ ]M [ ]F

Address:

Date of Birth:

Social Security #:

City,State: ,

Marital Status: [ ]Married [ ]Single [ ]Divorced

Alt Address:

Referring Physican:

Primary Physician:

Alt City,State:

Preferred Language:

Phone: [ ]Home [ ]Work [ ]Other

Email Address:

Phone: [ ]Home [ ]Work [ ]Other

Contact By:

Phone: [ ]Home [ ]Work [ ]Other

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Phone:

Employer:

CONTACTS

GUARANTOR

[X]Same as Patient

Name:

Address:

City,State:

EMPLOYMENT

Employer:

Phone:

Alt Phone:

Social Security #:

Date of Birth:

PRIMARY INSURANCE [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party:

Insured Phone:

Company:

Address:

City,State:

Copay Amount:

Relationship to Primary Insured/Guarantor:

Social Security #:

Insured ID:

Policy Group:

Date of Birth:

SECONDARY INSURANCE [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party:

Insured Phone:

Company:

Address:

City,State:

Relationship to Secondary Insured/Guarantor:

Social Security #:

Insured ID:

Policy Group:

Date of Birth:

AUTHORIZATION TO RELEASE INFORMATION: I hereby assign to New York Cardiology Associates to release information that may be necessary to process claims. I have been provided a copy of the Notice of Privacy Practices.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign to New York Cardiology Associates any and all health care benefits otherwise payable to me for medical treatment. I understand that I am financially responsible for any balance not covered by my insurance.

ASSIGNMENT OF MEDICARE BENEFITS: I request payment of Medicare benefits either to myself or to New York Cardiology Associates for services rendered to me.

Signature: ______________________ Date: ____________