

PATIENT INFORMATION SHEET

Name: _____ Sex: _____ Age: _____ Date of Birth: __/__/____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: () _____ Social Security #: _____ - _____ - _____

Work Phone #: () _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Spouse Name: _____ Date of Birth: __/__/____ Work Phone#: () _____

Notify in Emergency (Someone not living with you): _____

Address: _____ Phone #: () _____

Primary Care Physician: _____

Physician who referred you to us: _____

How did you locate us: Yellow Pages Website Referring Physician Billboard

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____

Name of Insured: _____ Social Security #: _____

Relationship: _____ Date of Birth of Insured: _____

Secondary Insurance: _____ Policy #: _____

Name of Insured: _____ Social Security #: _____

Relationship: _____ Date of Birth of Insured: _____

Tertiary Insurance: _____ Policy #: _____

Name of Insured: _____ Social Security #: _____

Relationship: _____ Date of Birth of Insured: _____

Release of Information

Georgia Heart & Vascular Center, P.C. is committed to protecting the privacy of our patients. Therefore, we will not give test results, medical information, financial information or other private health information to anyone other than the patient, guardian, or referring doctor, nor leave messages about test results on voicemail or an answering machine without your permission.

Please indicate your preferences below:

You may leave a message on my answering machine or voice mail **Yes** **No**

You may provide private health information about me as indicated below: **Yes** **No**

Under HIPAA regulations we may provide this information to other healthcare entities involved in your care and insurance companies for billing purposes without your permission. **Yes** **No**

If you would like for us to give your test results to anyone other than you, please list their name(s) and relationship below.

You may give my test results to:

_____ **Relationship:** _____ **Contact Number** _____

_____ **Relationship:** _____ **Contract Number** _____

Patient Signature: _____ **Date:** _____

Patient or guardian signature _____ **Date signed** _____

Printed patient name _____

Relationship of guardian (if applicable) _____

INSURANCE INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize **Georgia Heart and Vascular Center, P.C.**, to release medical information to my insurance companies of treatment and diagnoses necessary to process claims. I authorize assignment of benefits to be paid to **Georgia Heart and Vascular Center, P. C.**, for services rendered.

A photocopy of this shall be considered as valid as the original.

Patient Signature: _____ Insured Signature: _____

MEDICARE PATIENT’S LIFETIME CONSENT

I authorize the payment of Medicare Benefits to be made behalf to Georgia Heart and Vascular Center, P.C., for services rendered to me by that Physician. I also authorize the release of medical information about me to the Center for Medicare and Medicaid Services (CMS) or its agents necessary to process benefits.

Patient Signature: _____

NOTICE OF PRIVACY PRACTICES & NOTICE OF INDIVIDUAL RIGHTS

I acknowledge by signing below that I have received the “NOTICE OF PRIVACY PRACTICES AND INDIVIDUAL RIGHTS”.

Patient Signature: _____ Date: _____