MID-ATLANTIC SURGICAL ASSOCIATES, P.C.

PATIENT INFORMATION

Name______________________________ Soc. Sec. #______________

Address______________________________ City______________ State________ Zip________

Home Phone______________________________ Cell Phone______________________________

Sex ☐ M ☐ F Age________ Birthdate______________ ☐Single ☐ Married ☐ Widowed ☐Separated ☐ Divorced

Email Address:______________________________ Occupation______________

Preferred Method of Communication (for appointment reminders) ☐ Email ☐ Text ☐ Postcard

Emergency Contact:______________________________ Relationship to Patient______________

Emergency Contact Phone______________________________

Referring Cardiologist or Self Referred ______________, ______________ Phone # ______________

Primary Care Physician______________________________ Phone # ______________

Pharmacy Name/Location:______________________________ Phone # ______________

PRIMARY INSURANCE

Insurance Company______________________________

I.D. #______________________________ Group#______________

Subscriber Name(if different from patient's) ______________________________

Relation to Patient______________ Birthdate______________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐Yes ☐ No

Insurance Company______________________________

I.D. #______________________________ Group #______________

Subscriber Name (if different from patient's) ______________________________

Relation to patient______________ Birthdate______________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO MID-ATLANTIC SURGICAL ASSOCIATES

I authorize my doctor/hospital to release (either in writing or verbally) any medical information regarding treatment or testing which may be needed for patient care as well as processing claims for medical insurance (or managed care) benefits relative to medical history (including pre-certification and verification, if necessary), or which may be needed to conduct continued care planning to Mid-Atlantic Surgical Associates.

Physician/Hospital: ______________________________

Information Requested:______________________________

ASSIGNMENT AND RELEASE

I authorize payment of medical insurance benefits (including managed care and Medicare when applicable) directly to Mid-Atlantic Surgical Associates. I hereby agree to pay for charges not covered or approved by my medical insurance company or managed care organization. I understand that some insurance and managed care entities require pre-approval of certain hospitalizations, procedures and surgeries, and it may be my responsibility to obtain appropriate pre-approvals.

______________________________ ______________________________ ______________

Patient's Signature Responsible Party's Signature Date