SOUTHERN CARDIOVASCULAR ASSOCIATES, PC

PATIENT INFORMATION

CELL PHONE # _____

PATIENT NAME (LAST, FIRST, MIDDLE)						HOME TELEPHONE
ADDRESS	CITY		STATE			ZIP CODE
PATIENT'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)				WORK TELEPHONE
SEX ☐M ☐F	RACE	MARITAL STATUS ☐S ☐M ☐D ☐W	BIRTHDATE	RETIRED ☐Y ☐N	DISABLED ☐Y ☐N	SOCIAL SECURITY NO.
SPOUSE'S NAME		SPOUSE'S EMPLOYER		SPOUSE'S DATE OF BIRTH		SPOUSE'S WORK TELEPHONE
NEXT OF KIN (NOT LIVING WITH YOU)						DAYTIME TELEPHONE
FRIEND (NOT LIVING WITH YOU)						DAYTIME TELEPHONE
WHOM MAY WE CONTACT IN CASE OF EMERGENCY?						DAYTIME TELEPHONE
WHOM MAY WE THANK FOR REFERRING YOU?						DAYTIME TELEPHONE
DO YOU HAVE A LIVING WILL?		EMAIL ADDRESS				
PERSON RESPONSIBLE FOR PAYMENT				RELATION TO PATIENT		
ADDRESS	CITY	STATE	ZIP CODE	HOME TELEPHONE		SOCIAL SECURITY NO.
BIRTHDATE	EMPLOYER					WORK TELEPHONE
NAME OF PRIMARY INSURANCE CO.	CO PAY	CONTRACT NO.		GROUP NO.		EFFECTIVE DATE
NAME OF INSURED (AS IT APPEARS ON YOUR INSURANCE CARD)		(IF PATIENT IS A MINOR BIRTHDATE OF INSURED)				
NAME OF SECONARY INSURANCE CO.		CONTRACT NO.		GROUP NO.		EFFECTIVE DATE
NAME OF INSURED (AS IT APPEARS ON YOUR INSURANCE CARD)						

II understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. "Should collection proceedings become necessary, I agree to pay all costs of collection including a reasonable attorney's fee and do hereby waive all rights of exemption under the constitution and the laws of the state of Alabama or any other state". I have read all the information on the sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status of the above information.

Signature _____ Date _____

Signature Of Parent (if patient is a minor) _____ Date _____