Cardiac Care Associates Patient Demographics (*Confidential*)

Please Print

Today's Date:_____

Patient Name_____Birthdate:_____
First Name **Last Name** **Middle Initial**

Street Address_____

City _____State _____Zip Code_____

Home Phone: _____Cell Phone: _____Work Phone:_____

Sex: ☐M ☐F Marital Status: ☐M ☐S ☐D ☐W ☐Other Social Security #_____

Patient Employed By_____

This section must be completed if you are not the subscriber of the insurance.

Responsible Party:_____Birthdate:_____

Relationship to Patient:_____ Responsible Party Social Security #_____

Primary Insurance Company_____ Insurance Phone #_____

ID#_____ Group#_____

Secondary Insurance Company _____Insurance Phone #_____

ID#_____ Group#_____

Who Referred You To This Practice_____

Primary Care Physician (1st and last name)_____ Phone #_____

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I, the undersigned, authorize Cardiac Care Associates, P.C. to speak with the person listed below regarding my medical care.

_____ _____ _____
Authorized Person/Emergency Contact Relationship to Patient Phone number

I, the undersigned, authorize Cardiac Care Associates, P.C. to leave a voice mail message at the following number/s_____. Messages may at times include some protected health information, including appointment reminders, test results and instructions. I understand that with my signature I am authorizing the release of oral communication by Cardiac Care Associates, P.C. to this voice mail number/s and thereby release Cardiac Care Associates, P.C. and their staff from all legal responsibility that may arise from the act hereby authorized.

I agree that all above information is correct to the best of my knowledge.

Patient/Responsible Party Signature _____Date_____