HEART CARE OF THE POCONOS, PC

Patient Name:____________________ Sex: M F Marital Status: M S D W

DOB: __________________ Age: ___ Social Security #: ________________

Primary Language: ___________ Race: _________ Ethnicity: _____________

Mailing Address: ____

City: ______________________ State: ________ Zip Code: ______________

Home Phone: __________________ Work/Cell Phone: _________________

Spouse Name: __________________ Legal Guardian (if minor) ___________

Patient Employer: _______________ Email Address: ____________________

Family Physician/Address/Phone: ___________________________________

Referring Physician/Address/Phone: ________________________________

INSURANCE INFORMATION

Please provide cards so we may copy them for accuracy when submitting to Ins Co.

Primary Ins:__________________________ Policy #: _______________________

Subcriber Name: ______________________ DOB: _________ SS #:_____________

2nd Ins: ____________________________ Policy #: ________________________

Authorization: I request that payment of authorized Medicare benefits be made to Heart Care of the Poconos PC (HCOP) for any services furnished to me by HCOP. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

Signature: ___________________________ Date: ___________________________

Authorization: I authorize the above named facility to release information to the insurance carrier concerning my illness and treatment. I assign to the physician all payments for medical services provided to myself. I understand that I am responsible for all amounts not covered by my insurance company.

Signature: ____________________________ Date: ________________________

All demographic information requested in for compliance with the CMS guidelines. Please complete this form annually in its entirety.