

CASCADE HEART



NEW PATIENT INFORMATION SHEET

Name: (First:) _____ (MI) _____ (Last) _____
Date of Birth _____ Age _____ Sex: M ___ F ___ Marital Status S M W D
Address: (Street) _____
(City, State, ZIP) _____
Phone #: _____ Social Security #: _____
Work #: _____ Employer _____
Are you able to receive calls at work Yes No

Responsible Party or Spouse Information

Name: _____ Relationship to Patient _____
Address: (Street) _____
(City, State, ZIP) _____
Phone #: _____ Social Security #: _____
Work #: _____ Employer: _____
Are you able to receive calls at work Yes No

Insurance Information

Insurance Company: _____
Policy #: _____ Group #: _____
Insured's Name: _____ Relationship to Patient _____
Insured's Employer: _____ Phone: _____
Insured's Social Security #: _____ Date of Birth _____

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank You!

Insurance Information

Insurance Company: _____ Phone #: _____
Policy #: _____ Group #: _____
Insured's Name: _____ Relationship to Patient _____
Insured's Employer: _____ Phone: _____
Insured's Social Security #: _____ Date of birth _____

I hereby assign my insurance benefits to Cascade Heart. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature _____ Date _____