

Patient Data

PATIENT LAST NAME	FIRST	MI	SEX	BIRTHDAY	AGE	Do You Smoke?	Marital Status?
CURRENT MAILING ADDRESS			CITY		STATE	ZIP	PHONE
PERMANENT ADDRESS			CITY		STATE	ZIP	PHONE
PATIENTS EMPLOYER			OCCUPATION			SOCIAL SECURITY #	
EMPLOYER ADDRESS			CITY		STATE	ZIP	PHONE
RESPONSIBLE PARTY							
RESPONSIBLE PARTY			BIRTHDATE	RELATIONSHIP		SPOUSE NAME IF DIFFERENT	
ADDRESS			CITY		STATE	ZIP	PHONE
EMPLOYER NAME			OCCUPATION				
EMPLOYER ADDRESS			CITY		STATE	ZIP	PHONE
INCASE OF EMERGENCY NOTIFY							
NAME OF NEAREST LIVING RELATIVE NOT LIVING WITH PATIENT			RELATIONSHIP				
ADDRESS			CITY		STATE	ZIP	PHONE
INSURANCE INFORMATION							
PATIENTS PRIMARY INSURANCE COMPANY			GROUP NAME OR #			POLICY NUMBER	
INSURANCE ADDRESS			CITY			STATE	ZIP
POLICY HOLDERS NAME			POLICY HOLDERS SS#			INSURANCE PHONE #	
PATIENTS SECONDARY INSURANCE COMPANY			GROUP NAME OR #			POLICY #	
INSURANCE ADDRESS			CITY			STATE	ZIP
POLICY HOLDERS NAME			POLICY HOLDERS SS#			INSURANCE PHONE #	
CHAMPUSNA	ID CARD	DATE	BRANCH OF SERVICE		DUTY/STATION	GRADE/RANK	
REFERRED BY							

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I HEREBY AUTHORIZE PHOENIX HEART PLLC., TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS SERVICES DESCRIBED ABOVE, I UNDERSTAND I AM RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION

Signature _____

Date _____