



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	
<b>RESPONSIBLE PARTY</b>							
RESPONSIBLE PARTY		BIRTHDATE	RELATIONSHIP		SPOUSE NAME IF DIFFERENT		
ADDRESS		CITY		STATE	ZIP	PHONE	
EMPLOYER NAME		OCCUPATION					
EMPLOYER ADDRESS		CITY		STATE	ZIP	PHONE	
<b>INCASE OF EMERGENCY NOTIFY</b>							
NAME OF NEAREST LIVING RELATIVE NOT LIVING WITH PATIENT		RELATIONSHIP					
ADDRESS		CITY		STATE	ZIP	PHONE	
<b>INSURANCE INFORMATION</b>							
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 \_\_\_\_\_