Patient Information

Your Name: ____ Birth Date: ____________________

(First) (MI) (Last)

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other: ______________

Address: _________________________________ City: _______________State: _____ Zip: _________

Primary Phone: __________________________ Secondary Phone: ______________________________

Gender: ☐Male ☐ Female Social Security #: _____________________________________

Referring Physician: _________________________ Primary Care Physician______________________

Optional Questions

Preferred Language:______________ Race: ☐American Indian/Native Alaskan ☐ Black/African American

☐Asian ☐Native Hawaiian/Pacific Islander ☐White ☐ Hispanic/Latino ☐Other

Responsible Party

Name: _______________________________ Address: ____________________________________

City: _________________ State: ______ Zip: _______________ Phone: ______________________

Emergency Contact ☐ I authorize HeartCare Associates of AZ to release health information to my Emergency Contact

Name: _____________________________ Relationship: _____________ Phone: __________________

Additional Information

Occupation: __________________________________ Employer: ___________________________

How did you hear about us? ☐Friend/Family ☐Our Website ☐Other Website ☐Primary Care Physician

☐Social Media ☐Radio ☐ Magazine/Other Publication ☐Online Review/Rating Site

Insurance Information

Primary Insurance Company: ___________________________________ Relation to Subscriber ________

ID#: ____________________________________ Group #: ____________________________________

Subscriber Name: _______________________ Birth Date:____________ SSN _____________________

Secondary Insurance Company: _________________________________ Relation to Subscriber ________

ID#: ____________________________________ Group #: ____________________________________

Subscriber Name: _______________________ Birth Date:____________ SSN _____________________

______☐ **AUTHORIZATION**: I assign all medical/surgical benefits to and understand if eligibility of insurance cannot be verified or if deductible has not been met, I will be responsible for the cost of all medical services rendered. I hereby authorize payment directly to Heart One Associates for the surgical and and/or medical benefits, if any, otherwise payable under terms of my insurance.

______☐ **PATIENT WAIVER**: I hereby authorize Heart One to release any information acquired in the course of my examination or treatment. I hereby authorize the physician, hospital, or medical facility to provide all information on my medical history and treatment to Heart OneAssociates. I hereby authorize photocopies of this form and my signature to be as valid as the original.

______☐**REFERRALS**: If you are an HMO or managed care patient, you will need to obtain a referral form from your primary care doctor. It is the patient's responsibility to obtain the referral prior to your visit. Please initial even if you do NOT have an HMO policy. This states you acknowledge our policy if your insurance changes in the future.

______☐**MEDICARE PATIENTS ONLY**: I request payment of authorized Medicare benefits be made on behalf to Heart One Associates for any services furnished to me by the physician, I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

______☐**I have read and understand the information on this form.**

______________________________________ ________________________

(Signature) (Date)