Midcoast Cardiovascular Associates, A Professional Corporation

Patient Information Form

*** *Please Print* ***

Name _____ Home Phone _____ Work Phone _____

Address _____ City _____ State ____ Zip _____

Sex (circle one) M F Birth date _____ SS # _____

E-mail Address _____ Cellular Phone # _____

Employer _____ Employer Address _____

Spouse/Parent _____ SS# _____ Spouse's Employer _____

Employer Address _____ Work Phone _____

Nearest Relative (not living with you) _____ Daytime Phone _____

Emergency Contact _____ Daytime Phone _____

Who may we thank for referring you to Midcoast Cardiovascular Associates?

_____

Phone # _____ Or, how did you hear about us? _____

Insurance Information

PRIMARY Insurance _____ Effective Date _____

Cardholder Name _____ Date of Birth _____ Relationship to Patient _____

Certificate/ID # _____ Group/Union _____ Plan _____
Family Coverage? (circle one) Yes No

SECONDARY Insurance: _____ Effective Date: _____

Cardholder Name _____ Date of Birth _____ Relationship to Patient _____

Certificate/ID # _____ Group/Union _____ Plan _____
Family Coverage? (Circle one) Yes No

ALLERGIES: Please List _____

I authorize any holder of Medical Information about me/ my family to release information to third party payors in order to determine benefits for services provided. I authorize payment by my third party payers directly to Midcoast Cardiovascular Associates. I permit a copy of this authorization to be used as the original. I have verified that Midcoast Cardiovascular Associates is the facility I/my family must use for the insurance contract under which I/my family is covered. I understand that if the previous is not true, I am responsible for payment of charges related to services, supplies, products or equipment provided to me or my family.

I authorize the physicians and staff of Midcoast Cardiovascular Associates to render Medical treatment to me or my family. Except for Medical emergencies, any patient/guardian who refuses to complete and sign this authorization for treatment may be denied service. I have read and agreed to the above conditions. I also verify I received a notice titled "The Federal Truth in Lending/Billing Act and Financial Agreement" and agree to all conditions therein.

_____ _____ _____ _____ _____

Signature Date Signature Date

_____ _____ _____ _____

Signature Date Signature Date