FIVE TOWNS HEART IMAGING MEDICAL, P.C.

650 Central Ave., STE K
Cedarhurst, NY 11516
Tel: (516)-804-8590   Fax: (516)-804-8591

PATIENT INFORMATION

NAME: ______________________ **D.O.B:** ______________

ADDRESS: ______________________

CITY: ______________ **STATE:** ____________ **ZIP:** ________

HOME TEL: ______________ **CELL TEL:** ______________

MARITAL STATUS: __________ **SEX: M F SSN:** ______________

REFERRING PHYSICIAN: ______________________

TEL: ______________ **FAX:** ______________

EMERGENCY CONTACT

EMERCENCY CONTACT: ______________ **RELATION:** ________

HOME TEL: ______________ **CELL TEL:** ______________

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________________

ID#: ______________ **GROUP:** ______________

POLICY HOLDER: ______________ **D.O.B.:** ________

RELATIONSHIP TO PATIENT: ______________________

SECONDARY INSURANCE: ______________________

ID#: ______________ **GROUP:** ______________

POLICY HOLDER: ______________ **D.O.B.:** ________

RELATIONSHIP TO PATIENT: ______________________

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician, any information needed to this or related Medicare or Health Insurance claim. I permit a copy of this authorization used in place of the original and request payment of insurance benefits either to myself or to the party who accepts assignment.

SIGNATURE: ______________________ Date: ________

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Date:_________________________

I ____________________________________, acknowledge, that I have been provided with a copy of HIPPA compliance privacy notice.

Signature:____