PRINCETON INTERVENTIONAL CARDIOLOGY, P.A.

800 BUNN DRIVE

SUITE 101

PRINCETON, NJ 08540

**PATIENT INFORMATION**

 **NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SOCIAL SECURITY #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LAST FIRST INITIAL

 **ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CITY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STATE** \_\_\_\_\_\_ **ZIP** \_\_\_\_\_\_\_\_\_\_

**HOME PHONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CELL PHONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEX**: [ ] M [ ] F **AGE** \_\_\_\_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_\_\_ [ ] SINGLE [ ] MARRIED [ ] WIDOWED [ ] SEPERATED [ ] DIVORCED

 **E-MAIL ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PRIMARY LANGUAGE SPOKEN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RACE**: [ ] AMERICAN INDIAN [ ] ASIAN [ ] AFRICAN AMERICAN **ETHNICITY**: [ ] HISPANIC [ ] NON-HISPANIC . [ ] HISPANIC [ ] NATIVE HAWIAAN [ ] WHITE [ ] DECLINE [ ] DECLINE

**PATIENT EMPLOYED BY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] FULL [ ] PART [ ] RETIRED

**BUSINESS ADDRESS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **BUSINESS PHONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE DOCTOR** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **ADDRESS AND PHONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN WHO REFERRED YOU TO OUR OFFICE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **ADDRESS AND PHONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN CASE OF EMERGENCY WHO SHOULD BE CONTACTED?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PHONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ANY KNOWN ALLERGIES TO MEDICATIONS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE COVERAGE**

|  |  |
| --- | --- |
| **PRIMARY INSURANCE COMPANY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**I.D. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_PERSON RESPONSIBLE FOR ACCT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBSCRIBER ON INSURANCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP TO PATIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBSCRIBERS SOCIAL SECURTIY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBSCRIBERS DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **SECONDARY INSURANCE COMPANY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**I.D. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_PERSON RESPONSIBLE FOR ACCT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBSCRIBER ON INSURANCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP TO PATIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBSCRIBERS SOCIAL SECURTIY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBSCRIBERS DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ASSIGNMENT AND RELEASE**

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS AND/OR MAJOR MEDICAL BENEFITS, FOR ANY AND ALL UNPAID SERVICES TO INCLUDE MEDICARE, BLUE CROSS/BLUE SHEILD, HMO’S. PRIVATE INSURANCE CARRIERS, AND OTHER COVERED HEALTH PLANS TO:

**PRINCETON INTERVENTIONAL CARDIOLOGY, P.A**

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY SAID INSURANCE AND FOR SERVICES NOT ENTITLES FOR PAYMENTS BY MEDICARE, HMO’S, AND ALL OTHER HEALTH PLANS, IF APPLICABLE. IF COVERED BY MEDICARE BENEFITS, I UNDERSTAND THAT UNDER FEDERAL LAWS GOVERNING MEDICARE, I AM MANDATED BY LAW TO PAY MY DEDUCTIBLE AND 20% COPAYMENT. I ALSO AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO SECURE PAYMENT.

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RESPONSIBLE PARTY SIGNATURE DATE