



# Comprehensive Cardiovascular

Leading the fight against heart disease

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DATE: \_\_\_\_\_

PLEASE PRINT AND COMPLETE EVERY BLANK ON THIS FORM

|  |  |  |                |                |                |                       |  |                        |     |
|--|--|--|----------------|----------------|----------------|-----------------------|--|------------------------|-----|
| <b>PATIENT</b>   |  |  |                |                |                |                       |  |                        |     |
| LAST NAME  |  |  | FIRST          |                | MIDDLE         |                       | HOME PHONE   |                        |     |
| ADDRESS  |  |  |                |                |                |                       | WORK PHONE   |                        |     |
| CITY   |  |  | STATE          |                | ZIPCODE        |                       | CELL PHONE   |                        |     |
| SOCIAL SECURITY NO.  |  |  | SEX            |                | MARITAL STATUS |                       | E-MAIL ADDRESS   |                        |     |
| DATE OF INJURY   |  | IF YOU WERE INJURED (CIRCLE ONE)<br>ON THE JOB    AT HOME    AUTO ACCIDENT |                |                | REFERRED BY    |                       | DATE OF BIRTH  |                        | AGE |
| EMPLOYED BY  |  |  |                |                |                |                       | OCCUPATION   |                        |     |
| EMPLOYER ADDRESS   |  |  |                |                |                |                       | HOW LONG EMPLOYED?   |                        |     |
| EMPLOYER CITY  |  |  | EMPLOYER STATE |                | EMPLOYER ZIP   |                       | PREVIOUSLY TREATED IN THIS OFFICE?   |                        |     |
| EMERGENCY CONTACT PERSON   |  |  |                | RELATION       |                | PHONE                 |  | YOUR NAME AT THAT TIME |     |
| LAST NAME  |  |  | FIRST          |                | MIDDLE         |                       | HOME PHONE   |                        |     |
| ADDRESS  |  |  |                |                |                |                       | WORK PHONE   |                        |     |
| CITY   |  |  | STATE          |                | ZIP            |                       | CELL PHONE   |                        |     |
| SOCIAL SECURITY NO.  |  |  | SEX            |                | MARITAL STATUS |                       | E-MAIL ADDRESS   |                        |     |
| EMPLOYED BY  |  |  |                |                |                |                       | OCCUPATION   |                        |     |
| EMPLOYER ADDRESS   |  |  |                |                |                |                       | HOW LONG EMPLOYED?   |                        |     |
| EMPLOYER CITY  |  |  | EMPLOYER STATE |                | EMPLOYER ZIP   |                       |  |                        |     |
| <b>NAME OF PRIMARY INSURANCE CARRIER</b>   |  |  |                |                | ADDRESS        |                       |  | TELEPHONE              |     |
| CITY   |  |  | STATE          | ZIP            | INSURED PARTY  |                       |  | DATE OF BIRTH          |     |
| IDENTIFICATION NO.   |  | EMPLOYER COVERAGE?   |                | EFFECTIVE DATE | GROUP          |                       | PATIENT'S RELATIONSHIP TO INSURED (circle one)<br>SELF    SPOUSE    CHILD    PARENT<br>OTHER |                        |     |
| <b>NAME OF SECONDARY INSURANCE CARRIER</b>   |  |  |                |                | ADDRESS        |                       |  | TELEPHONE              |     |
| CITY   |  |  | STATE          | ZIP            | INSURED PARTY  |                       |  | DATE OF BIRTH          |     |
| IDENTIFICATION NO.   |  | EMPLOYER COVERAGE?   |                | EFFECTIVE DATE | GROUP          |                       | PATIENT'S RELATIONSHIP TO INSURED (circle one)<br>SELF    SPOUSE    CHILD    PARENT<br>OTHER |                        |     |
| <p>1. I HEREBY ASSIGN THE INSURANCE BENEFIT PAYMENT, BOTH BASIC AND MAJOR MEDICAL TO WHICH I AM ENTITLED, DIRECTLY TO THE DOCTOR RENDERING SERVICE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THE ASSIGNMENT. A PHOTOCOPY OF THIS AUTHORIZATION IS ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL. 2. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT TO ANOTHER PHYSICIAN OF MY CHOICE, MY INSURANCE COMPANY, MY ATTORNEY OR TO ME AT MY ABOVE ADDRESS, WITHIN 1 YEAR OF THE DATE OF THIS SIGNATURE.</p> |  |  |                |                |                |                       |  |                        |     |
| Date   |  | Signature (Guardian/Parent)  |                |                |                | If patient is a minor |  |                        |     |
| Witness  |  | Relationship to Patient  |                |                |                |                       |  |                        |     |