

FLORIDA HEART ASSOCIATES, P.L.
PATIENT DEMOGRAPHIC PROFILE

PATIENT #: _____

PATIENT'S NAME (Please Print): _____ SEX: _____ AGE: _____
BIRTHDATE: _____ SSN #: _____ MARITAL STATUS: _____
LOCAL ADDRESS: _____ TELEPHONE #: (____) ____ - ____
CITY: _____ FL. _____ ZIP CODE: _____
EMPLOYER: _____ WORK TELEPHONE #: (____) ____ - ____
SPOUSE'S NAME: _____ BIRTHDATE: _____ SSN #: _____
SPOUSE'S EMPLOYER: _____ SPOUSE'S WORK TEL. #: (____) ____ - ____

Part Time Residents Mailing Address

STREET: _____
CITY: _____ STATE: _____ ZIP CODE: _____

Who referred you to our office?

Reason for your referral:

(HMO Patient) Who is your local primary care doctor?

IN CASE OF EMERGENCY, PLEASE CALL: _____
RELATIONSHIP: _____ TELEPHONE #: (____) ____ - ____

Florida Heart Associates, P.L., participates in the provider networks of Medicare, Medicaid, and many major health plans. You are personally responsible for all co-payments, co-insurance and deductibles as defined by your plan coverage. These fees, and charges for "non-covered" services are due and payable at the time of your appointment. Medicare enrollees may be required to sign an "ABN" (Advanced Beneficiary Notice) Form if applicable.

PRIMARY INSURANCE CO.: _____
POLICY HOLDER: _____ POLICY #: _____
SECONDARY INSURANCE CO. _____
POLICY HOLDER: _____ POLICY#: _____

LIFETIME PRIMARY INSURANCE AND MEDICARE "B" SIGNATURE AUTHORIZATION

I HEREBY AUTHORIZE ANY HOLDER OF MEDICAL, OR OTHER PERTINENT INFORMATION ABOUT ME, TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, CENTERS FOR MEDICARE AND MEDICAID SERVICES, OT ITS INTERMEDIARIES OR CARRIERS, OTHER GOVERNMENT SPONSORED PROGRAMS, PRIVATE INSURANCE COMPANIES, OR THE BILLING AGENT OF FLORIDA HEART ASSOCIATES, ANY INFORMATION THAT IS REQUIRED FOR THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS BE ASSIGNED TO FLORIDA HEART ASSOCIATES, P.L.

MANAGED CARE AND HMO PATIENTS

I UNDERSTAND THAT I AM RESPONSIBLE FOR PREAUTHORIZATION APPROVAL FOR EACH APPOINTMENT AND/OR PROCEDURE PRIOR TO A SCHEDULED APPOINTMENT. WITHOUT PRIOR AUTHORIZATION, MY INSURANCE COMPANY WILL REFUSE PAYMENT OF CLAIM(S) AND I WILL BE PERONALLY RESPONSIBLE FOR PART OR ALL OF THE INCURRED BILL.

PATIENT'S SIGNATURE

DATE

WITNESS SIGNATURE

DATE