HEARTMASTERS MEDICAL ASSOCIATES, PC

Welcome to our clinic. In order to serve you properly, we will need the following information. (Please Print) All information will be strictly confidential.

Patient Name: Last Name, Fist Name, Middle Initial	Age	Sex	Date of Birth

Residence Address	City	State	Zip code

Home Number	Cell phone Number	Patient's Social Security Number
Email Address	**Work Phone Number**	**Alternative Phone Number**

Reason for visit	Referred by:

Phone and fax number of referring Physician if available		
Person to contact in case of emergency	**Relationship to patient**	**Phone number:**
Primary Care Physician:	**Address**	**Phone/Fax number**

Insurance Information

Primary Insurance company	Policy Number	Group Number

Subscriber Name	Subscriber DOB	Insurance Phone Number	Insurance through your employer?
Secondary Insurance	**Policy Number**	**Group Number**	
Subscriber name	**Subscriber DOB**	**Insurance Phone Number**	**Insurance through your employer?**

Health Insurance Authorization for assignment of benefits/information Release:

I, the undersigned authorize payments of medical benefits to Heart Masters Medical Associates, PC for any services furnished me by clinic staff. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment supplies provided to me. This information will be used for the purpose of evaluating and administering claims and benefits.

_____ _____

Patient , Parent or Guardian signature Date

"Best Of Health To You"

www.Heartmastermedicalassociates.com