

SOUND SHORE CARDIOLOGY, P.C.

NEW PATIENT INTAKE FORM

NAME: _____

ADDRESS: _____

_____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ SOCIAL SECURITY _____

OCCUPATION _____ MARITAL STATUS _____

EMPLOYER _____

ADDRESS _____ ZIP CODE _____

REFERRING PHYSICIAN _____ PHONE _____

EMERGENCY CONTACT _____

PHONE _____ RELATION _____

INSURANCE CARRIER _____

POLICY HOLDER _____ RELATION _____

POLICY # _____ GROUP # _____

CLAIMS ADDRESS _____

SECONDARY INSURANCE _____

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I AUTHORIZE SOUND SHORE CARDIOLOGY, P.C. TO FURNISH ANY RECORDS OF MEDICAL HISTORY FOR SERVICES RENDERED OR TREATMENT GIVEN TO ME FOR THE PURPOSE OF REVIEW OR FILING A CLAIM WITH MY INSURANCE CARRIER.

SIGNATURE _____ DATE _____

I AUTHORIZE MY INSURANCE CARRIER TO REIMBURSE SOUND SHORE CARDIOLOGY, P.C. DIRECTLY. I UNDERSTAND THAT I AM RESPONSIBLE FOR DEDUCTIBLES, CO INSURANCE, OR SPEND DOWN OR ANY PORTION OF THE BILL THAT MY INSURANCE COMPANY DOES NOT APPROVE OR COVER.

SIGNATURE _____ DATE _____