CAMP LOWELL CARDIOLOGY

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Date: _____ Patient Name: _____ DOB: _____

SS#:_____ Marital Status: S M W D Sex: M F

Telephone: (H) _____ (W) _____ (C) _____

Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

E-mail Address: _____ Employer: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____

Name of Policyholder: _____ DOB: _____

Group #: _____ Relationship to Patient: _____

Secondary Insurance: _____ ID #: _____

Name of Policyholder: _____ DOB: _____

Group #: _____ Relationship to Patient: _____

Tertiary Insurance: _____ ID #: _____

Name of Policyholder: _____ DOB: _____

Group #: _____ Relationship to Patient: _____

I authorize the release of any medical information necessary to process any insurance claims. I permit a copy of this authorization to be used in place of the original. I authorize payment of medical benefits to Camp Lowell Cardiology for services rendered. I understand that I am responsible for all charges not covered by my medical insurance. In addition, I am responsible for any deductions, co-payments and co-insurance amounts.

My signature below attests to the accuracy and completeness of the information provided on this page; it also indicates my full understanding of the above information.

_____ _____
Patient Signature Date