Gainesville Heart and Vascular Group, P.C.

Welcome to our office

PLEASE COMPLETE THE FORM

General Patient Information

Patient Name:_____
Last First Middle
SS#:_____-_____-_____ Date of Birth: _____ Age:_____
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Address: _____
_____

Home Phone: _____ Cell Phone:_____
Employer Name: _____ Phone: _____
Employer's Address: _____
_____
Primary Care Doctor: _____ Phone:_____
Who referred you to this practice?: _____
Emergency Contact Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____

Spouse/Guarantor's Name: _____
Last First Middle
SS#: _____-____-_____ Relation to Patient: _____ Date of Birth: _____
Home Phone: _____ Cell Phone: _____
Employer:_____Work Phone: _____
Employer Address: _____
_____

Insurance Information

Primary Insurance: _____
Name of Insured: _____
Member ID: _____ Group Number:_____ _____

Secondary Insurance_____
Name of Insured: _____
Member ID: _____ Group Number:_____ _____

All professional services rendered are charged to the patient. For your convenience, necessary forms will be completed to assist you with reimbursement from your insurance carrier. However, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION & ASSIGNMENT

I request that payment of authorized Medicare/Other Insurance company benefits be made to Gainesville Heart and Vascular Group, P.C. for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. The patient is responsible for the deductible, co-insurance, copayments, and non covered services which is the charge determination of your insurance company.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

Patient Signature: _____ Date: _____

Insured's Signature: _____ Date: _____