LAS SENDAS CARDIOLOGY

3514 N. Power Rd. Suite #107 Mesa, AZ 85215 P: 480-361-9949 F: 480-361-9969

PATIENT PROFILE/PRIVACY NOTICE

NAME: _____ BIRTHDATE: _____ SSN: _____ SEX: M F

LANGUAGE: _____ RACE: _____ ETHNICITY: _____ OCCUPATION: _____

MARITAL STATUS: ____ MARRIED ____ DIVORCED ____ WIDOWED ____SINGLE

ADDRESS: _____ HOME PHONE: _____ CELL: _____

CITY/STATE/ZIP:_____ EMAIL: _____

PRIMARY INSURANCE: _____ ID#:_____ INSURED PARTY: _____

SECONDARY INSURANCE: _____ ID#: _____ INSURED PARTY: _____

RESPONSIBLE PARTY: _____ DOB: _____ PHONE #: _____

ADDRESS: _____

I HEREBY GIVE AUTHORIZATION TO LEAVE/DISCUSS TEST RESULTS, MEDICATIONS, APPOINTMENTS, AND BILLING INFORMATION:

A MESSAGE ON MY HOME ANSWERING MACHINE: ____ YES ___ NO TEXT MESSAGE: ____ YES ____ NO

A MESSAGE ON MY CELLPHONE VOICEMAIL: ____ YES ___ NO WORK PHONE: ____ YES ____ NO

DISCUSS WITH FRIEND/FAMILY MEMBER: ____ YES ___ NO

IF YES: NAME: _____ RELATION: _____ PHONE #: _____

NAME: _____ RELATION: _____ PHONE #: _____

EMERGENCY CONTACT:

NAME: _____ RELATION: _____ PHONE #: _____

NAME: _____ RELATION: _____ PHONE #: _____

PHARMACY: _____ PHONE #: _____ CROSS STREETS: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

ADDRESS: _____ FAX #: _____

HOW DID YOU FIND US? (PLEASE BE SPECIFIC) _____

RELEASE OF BENEFITS AND INFORMATION

I CONSENT FOR MEDICAL TREATMENT AND I HAVE VERIFIED THE INSURANCE LISTED ON THIS SLIP AND AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE DOCTOR. I AM FINACIALLY RESPONSIBLE FOR ANY BALANCE DUE. I AUTHORIZE THE DOCTOR OR THE INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR THIS AND FUTURE CLAIMS. I HAVE READ AND UNDERSTAND THE OFFICE INSURANCE PAYMENT POLICY STATED ABOVE.

SIGNATURE_____ DATE _____