

The Cardiovascular Clinic of West Tennessee, P.C.

Patient Information Sheet

Welcome to our Practice

Please complete and sign: (attach copy of **insurance ID** card and picture of **drivers license**)

PATIENT INFORMATION (Please print)

First Name _____ MI _____ Last Name _____
Address _____ Appt # _____ City _____ State _____ Zip _____
Home Phone _____ Marital Status Single Married
Social Security # _____ Sex M F Date of Birth ___/___/___ Age _____
Employer _____ Work Phone _____
Employer's Address _____
Mother's Maiden Name _____ Student Status Full-Time Part-Time
Emergency Contact: Name _____ Relationship _____
Home Phone _____ Work Phone _____

RESPONSIBLE PARTY INFORMATION

If you are the responsible party, mark "self" and move down to "Insurance Information".

Patient's relationship to responsible party: Self Spouse Dependent SSN _____
First Name _____ MI _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Marital Status Single Married Divorced Widowed Separated
Date of Birth ___/___/___ Age _____ Sex M F
Employer _____ Work Phone _____
Employer's Address _____
Work Phone _____ Job Title _____

INSURANCE INFORMATION (Attach copy of insurance card)

Primary Insurance _____ Telephone Number _____
Group or Policy Number _____ Subscriber or I.D. Number _____
Subscriber Name _____ Effective Date _____ Co-Pay _____ Co-Ins/Deduct _____
Secondary Insurance _____ Telephone Number _____
Group or Policy Number _____ Subscriber or I.D. Number _____
Subscriber Name _____ Effective Date _____ Co-Pay _____ Co-Ins/Deduct _____

By your signature, you understand and acknowledge, that you will be responsible for the charges of any services provided that are denied, non-covered or not paid by your insurance, to include any collection fees if the account is in default.

Referred by _____

Signature _____