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 ______________________