

PATIENT INFORMATION

Preferred Name: _____

Patient Name: _____
Last First M.I.

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

E-Mail Address: _____

Patient's Employer: _____ **City:** _____ **Phone:** _____
Company

Date of Birth: _____ **Social Security Number:** _____

Marital Status: Single Married Divorced Widowed Other (*CIRCLE ONE*)

Patient Relationship to Responsible Party (below): Self Spouse Child Other **Sex:** M F

Primary Care Physician: _____ **Referred By:** _____

IF PATIENT IS A MINOR, WHO IS RESPONSIBLE OR INSURED PARTY

Responsible Party Name: _____
Last First M.I.

Address: _____

Date of Birth: _____ **Sex:** M F **Home Phone:** _____ **Work Phone:** _____

Social Security Number: _____

Responsible Party's Employer : _____
Company

City Phone

IN CASE OF EMERGENCY, PLEASE CONTACT (not living with you): _____
Name

Address
Phone Number: _____ **Relationship to Patient:** _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Secondary Insurance Company: _____

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. We will be happy to submit all claims on your behalf given that you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize Lakeshore Cardiothoracic and Vascular Surgery to release any medical information including diagnostics, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when deemed necessary to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

I authorize the physicians of Lakeshore Cardiothoracic and Vascular Surgery and their agents to share confidential medical information with the following family/friends:

Signed: _____ **Date:** _____

Patient, Parent or Guardian