Paris Cardiology Center

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Diagnostic & Interventional Cardiology
Diplomate American Board of Internal Medicine,
Cardiovascular Disease and Interventional Cardiology

DEMOGRAPHIC FORM

(Please Print)

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
Mailing address:		City:		State and zip code:		
Social Security no:	Email address (optional):		Home phone:	Cell phone:		
Occupation:	Employer:		Employer phone no.: ( )			
Referred to clinic by (please check one box):		❑ Dr.	❑ Insurance Plan	❑ Internet		
❑ Family	❑ Friend	❑ Close to home/work	❑ Flyer	❑ Other		
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date:	Address (if different):		Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No						
Occupation:	Employer:	Employer address:		Employer phone no.: ( )		
PRIMARY INSURANCE:						
Subscriber's name (if different):	Subscriber's S.S. no.:	Birth date:	ID#:	Group#:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
SECONDARY INSURANCE (if applicable):	Subscriber's name and birth date:		ID#:	Group#:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )		

APPOINTMENT CANCELLATION AND BILLING POLICY

We realize that emergencies occur, however in order to help us be available to patients who would like to be seen we request that you notify us within a minimum of 24-hours if you need to cancel or reschedule an appointment. A $25 "NO SHOW" FEE MAY APPLY. As a courtesy to our patients, we will bill your insurance for you. Keep in mind that even though your insurance will be billed you are ultimately responsible for your bill.

The above information is true to the best of my knowledge. I authorize Hands On Medicine to treat me. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hands On Medicine to release any information required to process my claims.

Patient/Guardian signature *Date*