PATIENT INFORMATION SHEET

Confidential Please Print Clearly

Date:_____ Marital Status (circle one) S M W D Separated

Here to see Doctor:_____ Reason:_____

Patient Name:_____
First Middle Last

Home Address: _____
Street City State Zip

Home Phone: (___)_____ Cell Phone: (___)_____ E-mail:_____

Occupation:_____ Date of Birth:_____ Gender: M / F Age:_____ SS#:_____

Primary Language:_____ Race: _____ Ethnicity: _____

Employer's Name:_____ Dept:_____ Phone: (___)_____

Employer's Address:_____
Street City State Zip

Referring Physician:_____ (___)_____
Name Address City/State/Zip Phone

Family Physician: _____ (___)_____
Name Address City/State/Zip Phone

Due to Federal HIPAA regulations Cardiothoracic & Vascular Surgical Associates, S.C. (CTVSA) may not release any information regarding your condition without your express permission. Please designate one (1) or two (2) family members and/or persons to whom we may discuss and/or release information relative you're your medical condition and sign below. This/These person/s should also be someone we can call in case of an emergency.

I, _____ give CTVSA and its representative's permission to discuss and/or release my personal and private medical information to/with those I have listed below. In addition, I acknowledge receipt of CTVSA's "Notice of Privacy Practices" and understand that CTVSA reserves the right to modify the privacy practices outlined in the notice.

Name Address City/State/Zip Phone
Relationship _____

Name Address City/State/Zip Phone
Relationship _____

✘Patient's Signature:_____ Date:_____

COPY OF INSURANCE CARD REQUIRED (COPY OF DRIVER'S LICENSE OR OTHER STATE ISSUED ID IN LIEU OF INSURANCE CARDS

POLICY HOLDER NAME:_____ ID#_____ GROUP #_____

RELATONSHIP TO PATIENT:_____

I request that payment of authorized Medicare benefits and MediGap Insurance, or any medical insurance program (BC/BS or any commercial insurance carrier) be made payable to CARDIOTHORACIC & VASCULAR SURGICAL ASSOCIATES, S.C. for any services provided to me by its associated physicians or allied health professionals. I authorize any holder of medical information or other information necessary to process claims on my behalf be released to HCFA and its agents needed to determine benefits or benefits for related services. I also authorize that the use of a copy of this authorization in place of the original. I understand that I am financially responsible for any amounts not paid by insurance (after appropriate contractual adjustments are made). I understand and agree to these conditions as a patient of this medical practice.

✘Patient's Signature:_____ Date:_____

Signature of Patient Representative:_____ Date:_____
(Required if patient is unable to sign or patient is a minor)

NOTE: Responsible Party if Other than Patient:

Relationship to Patient:_____ Name:_____

Home Phone: (___)_____ Work Phone: (___)_____ Soc. Sec. #:_____

Employer Name & Address:_____
Name Address City/State/Zip

Phone: (___)_____ Occupation:_____

Instructions to Provider: This second paragraph must be filled out for Medicare patients who have a MediGap Plan as secondary and you are a Medicare Provider. If you are a non-participating provider then paragraph two is optional if you do not file the MediGap.

MEDICARE PATIENT QUESTIONNAIRE

All Medicare patients must complete this questionnaire. A "YES" to any of the questions means Medicare may not be the primary insurance and another payer must be identified.

Patient name:_____ SSN#:_____

Insured's Name (if other than patient):_____ SSN#:_____

EMPLOYMENT: Employed? ☐ Yes ☐ No Employer:_____

Does your employer provide you with health insurance? ☐ Yes ☐ No

If applicable, does your spouse's employer provide you with health insurance? ☐ Yes ☐ No

INSURANCE: Do you have other health insurance? ☐ Yes ☐ No

AUTO/LIABILITY: Was your injury or condition caused by an accident? ☐ Yes ☐ No

If Yes answer: ☐ Auto ☐ Work ☐ Other

WORKER'S COMPENSATION: Date of accident:_____

END-STAGE RENAL DISEASE (ESRD): Are you entitled to Medicare due to ESRD and do you have other insurance?
☐ Yes ☐ No

BLACK LUNG: Are you entitled to Black Lung Benefits? ☐ Yes ☐ No

VETERANS: Do you receive Veterans' Benefits? ☐ Yes ☐ No

If you answered "YES" to any of the above questions, you must complete the following section:

Insurance:_____

Policy #:_____ Group #:_____ Group Name:_____

Policy Holder Name:_____ Benefits Verification #:_____

(Updated 01/14/12)