GOLDMAN AND MILLER CARDIOLOGY

welcome to our office.

Patient name:____ **date:**____________
last name — first — middle initial

Home address:____ **apartment #**______

city:_______________________ **state:**_______________ **ZIP Code:**__________

phone (home)______________ **(cell)**________________ **(work)**______________

email:____

SSN:______________ **gender:**__________ **birthdate:**________**marital status:**________

primary language:__________________ **race:**___________ **ethnicity:**__________

******primary physician:**__________________ **referral physician**__________________

ALLERGIES TO MEDICATION ____

case of emergency:________________ **phone (home)**___________ **(cell)**__________

legal guardian/next of kin, durable power of attorney___________________________

insurance information.

PRIMARY INSURANCE ____
subscriber name______________________________**subscriber date of birth**__________
contract number________________________ **group number**____________________

SECONDARY INSURANCE____
subscriber name______________________________ **subscriber date of birth**__________
contract number________________________ **group number**____________________

OTHER INSURANCE____
subscriber name______________________________ **subscriber date of birth**__________
contract number________________________ **group number**____________________

patient authorization: I request payment authorized Medicare, Medicaid, Medigap or any other insurance benefits be made on my behalf to Goldman and Miller cardiology, PC for any services furnished to me. I authorize any holder of medical information about myself to be released to the appropriate agents of my medical insurance company or companies. Only information needed to determine these benefits or the benefits payable for related services will be released. I understand that if more than one insurance company covers me, and the companies covering me disagree on which insurance is primary I will personally be held responsible for payment of all bills. I understand that I am responsible for all co-pays, deductibles and/or any denial of claim. I consent to electronic communication, whether by phone, email, text messaging, or automated messaging.

I have read the above and understand my obligations:

Signed____ **date**______________