

SJH Cardiology Associates

**Please Print Clearly & Fill Out Completely
Return in Envelope Provided**

Patient Name Last	First	M.I.	Social Security Number		
Address		City	State	Zip Code	
Date of Birth ()	Age Sex	Home Phone LJ Married	Sex D Male D Widowed	Marital Status D Single ()	D Divorced
Employer Name & Address			Work Telephone No. ()		
			Are you retired? D Yes D No If yes, from where?		
Spouse's or Guardian's Name or Guardian's First Social Security No.		M.I.	Last	Spouse's or Guardian's	Spouse's Date of Birth
Spouse's or Guardian's Employer Name & Address					
Spouse retired? D Yes D No If yes, from where?					
Contact Person (In Case of Emergency)			Phone Number ()	Relationship	
Referring Physician			Primary Care Physician		
<i>INSURANCE INFORMATION (Please list all insurance companies)</i>					
MEDICARE Primary Secondary	Medicare #:		Hospital Coverage - Part A Effective Date:		Medical Coverage - Part B Effective Date:
	Name as it appears on your Medicare card:				
BLUE SHIELD Primary Secondary	Policy Holder's Name: (from card)		ID# (Include letters)		Group #: Effective Date:
	Street Address:		City: State:		
MEDICAID	Insurance Company Name/Address:				Phone #:
	Insured Person's Name:				Group #:
	ID#: / Policy #: / Contract #:				Eff. Date:
OTHER INSURANCE	Insurance Company Name/Address:				Phone #:
	Insured Person's Name:				Group #:
	ID#: / Policy #: / Contract #:				Eff. Date:
COMPENSATION & NO FAULT	Employer at Time of Injury and Address:				Phone #:
	Date of Injury		Place of Injury		Comp Board #:
	Insurance Carrier Name and Address:				Carrier Case #:

PROFESSIONAL SERVICES ARE RENDERED FOR YOUR PERSONAL BENEFIT AND PAYMENT IN FULL IS YOUR RESPONSIBILITY.
Unpaid balances over 60 days old will be subject to Collection Action and the patient will be responsible for all reasonable costs of collection.

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claims. I request that payment under the medical insurance program be made to **SJH Cardiology Associates** for services provided to me during the period of my treatment or lifetime. In addition, I authorize release of medical information to my referring physicians.

Medicare Beneficiary Signature

Date

STATEMENT TO AUTHORIZE PAYMENT OF OTHER INSURANCE BENEFITS

I hereby authorize payment directly to **SJH Cardiology Associates** and the release of any information to my insurance company acquired in the course of my examination or treatment described herein, of the health benefits, if any, otherwise payable to me.

Insured or Authorized Person's Signature

Date