**Shadyside Cardiovascular, PLLC.**

**Patient Information Sheet**
(Please Print)

Date: _____________

First Name ___________________MI _______ Last Name ____________________________

Street Address ________________________________________________________________

City __________________________________ State ________ Zip Code ________________

Day Phone # _________________ Evening Phone # ________________ Sex: M F

Birth Date ____________ SS # ________________ Marital Status _______________________

Referring Physician: _________________________________Telephone # _______________

Address ___________________________________________________________________

Primary Care Physician, if different from above: __________________________________

Address ___________________________________________________________________

Emergency Contact (Name, Telephone #, Relationship):

___________________________________________________________________________

Allergies (Drug, Food, Other)____________________________________________________

Pharmacy Name and Telephone # _______________________________________________

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***Please have your insurance cards ready for photocopying***

Insurance Company ___________________________________________________________

Address ___________________________________________________________________

Policy # ____________________________ Group # _________________________________

Subscriber __________________________ Birth Date __________ Relationship___________

Secondary Insurance Company _________________________________________________

Address ___________________________________________________________________

Policy # ____________________________ Group # _________________________________

Subscriber __________________________ Birth Date __________ Relationship___________

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**Shadyside Cardiovascular, PLLC.**

# Patient Authorizations

## Authorization to Release Medical Information

I authorize Shadyside Cardiovascular, PLLC. to release protected health information to sponsoring and/or compensating agencies and their agents or designees. This authorization will also include other physicians or hospital in the event of an emergency.

## Authorization for Payment of Insurance Benefits

I authorize payment of insurance benefits be made directly to Shadyside Cardiovascular, PLLC. for services provided to me as of this date. I understand that I am financially obligated for any charges that my insurance company considers to be my responsibility.

## Authorization for Payment of Medicare Benefits

I authorize Shadyside Cardiovascular, PLLC. to release to the Social Security Administration or its intermediaries or carriers any protected health information needed for this or related Medicare claims. I assign the benefits payable for physician services directly to West Penn Cardiology Associates, P.C. and give my consent to this organization to submit a claim to Medicare for such services. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

## Authorization for Treatment

I voluntarily consent to medical examination and treatment by the employees and authorized agents of Shadyside Cardiovascular, PLLC. This includes any diagnostic procedures deemed in their professional judgment to be necessary or beneficial to my care. I acknowledge that no guarantees have been made to me as to the outcome of such examination or treatment of my condition.

Signature and Date ________________________Relationship if not patient ______________