Shadyside Cardiology Associates

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 Cardiology Associates, P.C.

Patient Authorizations

Authorization to Release Medical Information

I authorize West Penn Cardiology Associates, P.C. 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 West Penn Cardiology Associates, P.C. 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 West Penn Cardiology Associates, P.C. 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 West Penn Cardiology Associates, P.C. 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 ______________