



CONNECTED CARDIOVASCULAR CARE ASSOCIATES

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#: _____ Work#: _____

Preferred Method of for appointment reminders: Phone Text Email

Date of Birth: ____/____/____ Sex: Male Female SS#: _____

Race: _____ Ethnicity: Hispanic Non-Hispanic Preferred Language: _____

Marital Status: Single Married Divorced Widowed Occupation: _____

Referred by Family/ Friend/ Doctor: _____

Primary Care Provider _____ PCP Phone Number _____

Preferred Pharmacy: _____ City: _____ Phone #: _____

Intersection: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy/ID# _____

Name of Policy Holder: _____ DOB: ____/____/____ Group/Acct #: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance: _____ Policy/ID# _____

Name of Policy Holder: _____ DOB: ____/____/____ Group/Acct #: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

I hereby give my permission to Connected Cardiovascular Care Associates to disclose and discuss information related to my medical condition(s) to/with the following persons:

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

____ I do not wish to give consent for any person to have access to any information regarding my medical condition(s).

Emergency Contact: _____ Relationship: _____ Ph#: _____

This authorization shall remain in effect unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any records.

Signature of Patient or Legal Representative: _____

Printed Name and Relationship: _____ Today's Date: _____

