

PATIENT INFORMATION SHEET

Confidential

Please Print Clearly

Date: \_\_\_\_\_ Marital Status (circle one) S M W D Separated

Here to see Doctor: \_\_\_\_\_ Reason: \_\_\_\_\_

Patient Name: \_\_\_\_\_
First Middle Last

Home Address: \_\_\_\_\_
Street City State Zip

Home Phone: ( ) Cell Phone: ( ) E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M/F Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Dept: \_\_\_\_\_ Phone: ( )

Employer's Address: \_\_\_\_\_
Street City State Zip

Referring Physician: \_\_\_\_\_ ( )
Name Address City/State/Zip Phone

Family Physician: \_\_\_\_\_ ( )
Name Address City/State/Zip Phone

Due to Federal HIPAA regulations Cardiothoracic & Vascular Surgical Associates, S.C. (CTVSA) may not release any information regarding your condition without your express permission. Please designate one (1) or two (2) family members and/or persons to whom we may discuss and/or release information relative you're your medical condition and sign below. This/These person/s should also be someone we can call in case of an emergency.

I, \_\_\_\_\_ give CTVSA and its representative's permission to discuss and/or release my personal and private medical information to/with those I have listed below. In addition, I acknowledge receipt of CTVSA's "Notice of Privacy Practices" and understand that CTVSA reserves the right to modify the privacy practices outlined in the notice.

Name Relationship Address City/State/Zip Phone

Name Relationship Address City/State/Zip Phone

\*Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

COPY OF INSURANCE CARD REQUIRED (COPY OF DRIVER'S LICENSE OR OTHER STATE ISSUED ID IN LIEU OF INSURANCE CARDS)

POLICY HOLDER NAME: \_\_\_\_\_ ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

I request that payment of authorized Medicare benefits and MediGap Insurance, or any medical insurance program (BC/BS or any commercial insurance carrier) be made payable to CARDIOTHORACIC & VASCULAR SURGICAL ASSOCIATES, S.C. for any services provided to me by its associated physicians or allied health professionals. I authorize any holder of medical information or other information necessary to process claims on my behalf be released to HCFA and its agents needed to determine benefits or benefits for related services. I also authorize that the use of a copy of this authorization in place of the original. I understand that I am financially responsible for any amounts not paid by insurance (after appropriate contractual adjustments are made). I understand and agree to these conditions as a patient of this medical practice.

\*Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient Representative: \_\_\_\_\_ Date: \_\_\_\_\_
(Required if patient is unable to sign or patient is a minor)

NOTE: Responsible Party if Other than Patient:

Relationship to Patient: \_\_\_\_\_ Name: \_\_\_\_\_

Home Phone: ( ) Work Phone: ( ) Soc. Sec. #: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_
Name Address City/State/Zip

Phone: ( ) Occupation: \_\_\_\_\_

Instructions to Provider: This second paragraph must be filled out for Medicare patients who have a MediGap Plan as secondary and you are a Medicare Provider. If you are a non-participating provider then paragraph two is optional if you do not file the MediGap.

**MEDICARE PATIENT QUESTIONNAIRE**

All Medicare patients must complete this questionnaire. A "YES" to any of the questions means Medicare may not be the primary insurance and another payer must be identified.

Patient name: \_\_\_\_\_ SSN#: \_\_\_\_\_

Insured's Name (if other than patient): \_\_\_\_\_ SSN#: \_\_\_\_\_

**EMPLOYMENT:** Employed?  Yes  No Employer: \_\_\_\_\_

Does your employer provide you with health insurance?  Yes  No

If applicable, does your spouse's employer provide you with health insurance?  Yes  No

**INSURANCE:** Do you have other health insurance?  Yes  No

**AUTO/LIABILITY:** Was your injury or condition caused by an accident?  Yes  No

If Yes answer:  Auto  Work  Other

**WORKER'S COMPENSATION:** Date of accident: \_\_\_\_\_

**END-STAGE RENAL DISEASE (ESRD):** Are you entitled to Medicare due to ESRD and do you have other insurance?  
 Yes  No

**BLACK LUNG:** Are you entitled to Black Lung Benefits?  Yes  No

**VETERANS:** Do you receive Veterans' Benefits?  Yes  No

If you answered "YES" to any of the above questions, you must complete the following section:

Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Benefits Verification #: ( ) \_\_\_\_\_