Heart, Vascular & Vein of Tampa Bay
Consultative, Diagnostic & Interventional Cardiac, Vascular & Venous Disease

PATIENT INFORMATION SHEET

Last Name: _____ First Name: _____ MI: _____

Primary Address: _____ Apt. #_____
(Florida address required, if out-of-state, fill in secondary)

Secondary Address: _____ Alternate Phone: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ **Work Phone:** _____

E-mail: _____ **REFERRAL SOURCE:** ☐ PCP ☐ FRIEND

☐ NEWSPAPER AD ☐ HOSP _____ ☐ INTERNET ☐ OTHER: _____

Date of Birth: _____ **Marital Status:** _____ **Social Security:** _____

Sex: _____ **Race/Ethnicity (Optional):** _____

Employer: _____

Spouse's Name: _____ **Spouse's Work:** _____

Spouse's Employer: _____ **Number:** _____

Emergency Contact: _____ **Relationship:** _____

Primary Insurance: _____ Secondary Ins.: _____
(Primary insurance card @time of office visit to be copied) *(Present insurance card @time of office visit to be copied)*

Name of insured: _____ Relationship: _____

Date of Birth: _____ Social security #: _____

Primary Care Physician: _____
Please have insurance card(s) ready to be copied upon completion of your information sheet.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS. I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining any signature on each claim submitted, and the signature will bind me as though I personally sign the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. INSURANCE AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. If this account should be referred to a collection agency, (I will be responsible for any balances placed with collections). I have read and understand the office policy and procedures.

Driver's License #: _____ State licensed: _____

Patient's Signature: _____ Date: _____