We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help. We look forward to working with you.

PATIENT INFORMATION

Name: _____ Social Security # _____

Address: _____ City_____State_____ Zip_____

Home Phone: _____Cell Phone: _____ Email: _____

Sex [ ] M [ ] F Age _____ Birthdate _____ [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

The following information is requested for demographic purposes only:

Race - [ ] Unknown [ ] White [ ] African American [ ] American Indian/Native American [ ] Asian [ ] Hispanic [ ] Not Hispanic or Latino

Ethnicity - [ ] Unknown [ ] Hispanic or Latino [ ] Not Hispanic or Latino

Preferred Language - _____

Primary Care Provider: _____

Patient Employed by _____ Occupation _____ Work Phone_____

Business Address _____

In case of emergency, notify _____ Home Phone _____

Cell Phone_____ Relationship to patient _____

Whom may we thank for referring you? _____

PRIMARY INSURANCE

Person responsible for account _____Social Security #_____

Birthdate _____ Relation to Patient _____

Address (if different) _____City_____State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Responsible Employed by _____ Occupation _____Work Phone_____

Business Address _____

Insurance Company _____Contract# _____Group#_____Subscriber#_____

Insurance Phone_____Address_____

Name of other dependents under this plan_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? [ ] Yes [ ] No

Subscriber Name _____Social Security #_____

Birthdate _____ Relation to Patient _____

Address (if different) _____City_____State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Subscriber Employed by _____ Occupation _____Work Phone_____

Business Address _____

Insurance Company _____Contract# _____Group#_____Subscriber#_____

Insurance Phone_____Address_____

Name of other dependents under this plan_____

Please complete both sides.

AUTHORIZATION

I have reviewed the information on both this questionnaire and the patient intake form; it is accurate to the best of my knowledge. I understand that the providers will use this information to help determine appropriate treatment. If there is a change in my medical status, I will inform them. I give permission to Elko Cardiology Associates to administer and perform such procedures as may deemed necessary in the diagnosis and treatment of my cardiovascular disease.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the providers to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

NO SHOW AND CANCELLATION POLICY

Elko Cardiology Associates requires at least 24 hours' notice for all cancellations. Failure to provide 24 hours' notice AND failure to show for a scheduled appointment will result in a cancellation/no-show fee of $50.00. Patients who fail to show for three (3) appointments without notice may be terminated from our care.

Signature_____Date_____

Payment or co-pay is due in full at the time of check-in, unless prior arrangements have been approved.