Arizona Cardiovascular & Thoracic Surgeons, P.L.L.C.

First Name_____**MI**_____ **Last**_____

M_____**F**_____ **DOB**: _____ **SS#** _____

Address_____

City_____**ST**_____**Zip**_____

Home Phone_____ **Alt Phone**_____

Marital Status: S ___ M ___ D ___ W ____ **Spouse Name**_____

Referring Physician_____**Primary Care Physician**_____

Primary Insurance_____

ID #_____ **Group #**_____

Policy Holder Name_____

Secondary Insurance_____

ID #_____ **Group #**_____

Policy Holder Name_____

Emergency Contact Name_____ **Phone**_____

Patient Consent

With my consent, AZCVTS may call the following number _____and leave a message in reference to any information that assists the practice in carrying out my treatment. I hereby authorize AZCVTS to release any information required in the course of examination or treatment for medical or insurance purposes. _____

Authorization for Miscellaneous Charges

I understand that AZCVTS may charge me for any additional documents or paperwork that I request be completed on my behalf. I understand the charge amount will be made known to me before and that payment must be made to AZCVTS prior to any paperwork being completed. _____

Financial Responsibility

I understand that I am fully responsible for all charges regardless of insurance coverage, and I hereby authorize my insurance company to make payment directly to AZCVTS for any services rendered to me. _____

Release of Information

I authorize **AZCVTS** to release information regarding my medical diagnosis and treatment to the following person(s):

_____ _____

Signature_____**Date**_____