Please Note: So that we may maintain the most up to date and accurate information on our patients, in addition to the face sheet presented to you at every visit, we will request that you review and update this form at least once a year.

DATE:_____

PATIENT INFORMATION

Patient Name: First_____MI_____ Last_____ SS# _____

DOB: _____ Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Life Partner

Race: □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Declined
Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino □ Declined

Preferred Language: English_____ Spanish_____ Other_____

Do you have any communication difficulties/ special needs? Hearing Loss Interpreter Required Reading Difficulty Sight Impaired Other? Yes No

If yes, please list: _____

Address: _____Apt # _____ City_____St_____Zip _____

Phone: Home_____Cell_____ Work_____

E-Mail_____

Best Contact Method: □ Home □ Cell □ Work □ E-Mail □ Mail By checking one of the boxes I agree to receiving correspondence from Trident Heart and Vascular

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Disabled □ Retired Employer/School: _____

FINANCIALLY RESPONSIBLE PARTY

☐ **Same as Patient Information** *(If different, please complete section below)*

Name: First_____MI_____ Last_____

Relationship: Spouse Parent Guardian Other (Please Specify): _____

Address: _____Apt #_____ City_____St_____Zip _____

Phone: Home_____ Cell_____ Work_____

Email Address _____

Employer: _____

EMERGENCY NOTIFICATION

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

REFERRAL SOURCE

□ Friend/Family Member_____ □ Insurance Company_____

□ social Media_____ □ Newspaper/Magazine _____ □ Web Search_____ □ Event_____

□ Trident Website □ Another Physician/Provider _____ □ Other _____

□ Hospital / ED _____

Continue to the Back of this Page

FOR OFFICE USE ONLY:

*Patient Name*_____
*MRN*_____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

☐ **Do Not Release Information**

I authorize Trident Heart and Vascular and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Trident Heart and Vascular of changes or update. I authorize Trident Heart and Vascular to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____ Relationship_____ Phone_____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

Name _____ Relationship_____ Phone _____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

If you wish to receive your health information ***by email,*** please continue to read. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the Internet.
Initials _____

Please provide a copy of all Insurance Cards and a Driver's License / Photo ID

You will be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

INSURANCE INFORMATION

Medicare ID# _____

Do You Have Insurance Primary to Medicare? Yes No If Yes, Please List: _____

Medicare Supplement _____ ID# _____

Medicare Advantage Plan _____ ID#_____

Medicaid ID# _____

Or

Commercial Insurance

Primary Insurance_____ ID _____ Gp: _____

Policy Holder Name:_____ Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____ Employer_____

Secondary Insurance_____ ID: _____ Gp _____

Policy Holder Name:_____ Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____ Employer_____

MEDICATION REFILL

Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may require 48-72 hours. Please allow sufficient time for us to process your refill request.

Pharmacy Name_____ Address _____ Phone: _____

Patient/Guarantor Signature: Date: