MID-FLORIDA CARDIOLOGY SPECIALISTS **ACCOUNT:** ___________

Name: ________________________________Birthdate: __________ M or F
Address: ____
City, State and Zip Code: ____
Home Phone: (___) _________________ Cell Phone:__________________
SS# ____________________________ Marital Status: S M W D
Primary Care M.D. ___________________ M.D. Phone: ______________
Are you retired? Yes ___ No ___

INSURANCE INFORMATION:

In order to file your insurance, we need accurate information.

Name of Insurance Company: ____
Social Security: ____
Policyholder: _______________________ Policy Number: ________________
Group Number: _____________________ Phone Number: ________________
Address for sending claims: ____
Employer: ___________________________Phone Number: ______________
Date of Birth of policyholder if not the patient: _______________________

Secondary Insurance Information:

Name of Insurance Company: ____
Policyholder: ________________________Policy Number: ________________
Group Number: _____________________ Phone Number: ________________
Address for sending claims: ____
Employer: __________________________ Phone Number: ________________
Date of Birth of policyholder if not the patient: _______________________

Who may we thank for referring you? ____________________________________

I authorize MID-FLORIDA CARDIOLOGY SPECIALISTS to release any information necessary to expedite insurance claims on my behalf. ***I have read, signed and received the Mid-Florida Cardiology Specialists Financial Policy attached to this form.***

Signature of patient: ___________________________Date: ______________

RELEASE OF RECORDS:

I hereby authorize ___________________________ to release to ____________________any information including the diagnosis and records of any treatment or examination rendered to me during the period from ________________ to _____________________.

Signature: ___________________________________Date: ________________

(Updated 04/03/2007)