PATIENT INFORMATION SHEET

DEMOGRAPHIC INFORMATION	**TODAYS DATE:**_____	**ACCOUNT NUMBER:** _____
	LAST NAME:	_____EMPLOYED _____NOT EMPLOYED
	FIRST NAME: MI:	_____F/T STUDENT _____P/T STUDENT
	ADDRESS:	EMPLOYER/SCHOOL:
		HOME PHONE #: CELL:
	CITY:	WORK PHONE #: EXT:
	STATE: ZIP:	DATE OF BIRTH:
	_____MALE _____FEMALE	SOCIAL SECURITY #:_____/_____/_____
	MARITAL STATUS: _____SINGLE _____MARRIED _____OTHER	
	DO YOU HAVE A PRIMARY CARE PHYSICIAN? ___YES ___NO _____	**PREFERRED PHARMACY:**
		NAME:
	PCP NAME:	ADDRESS:
	ADDRESS:	CITY/STATE/ZIP
	CITY/STATE/ZIP:	PHONE:
	PHONE:	
ADDITIONAL INFO	**NEXT OF KIN:**	IF NO, MAY WE DISCUSS YOUR PERSONAL HEALTH INFORMATION WITH SOMEONE ELSE?
	NAME:	NAME:
	RELATIONSHIP:	RELATIONSHIP:
	PHONE: HM_____WK_____EXT_____	PHONE: HM:
	MAY WE DISCUSS YOUR PERSONAL HEALTH INFORMATION WITH THIS PERSON? ___YES ___NO	WK:
OTHER	**1. Do you consider yourself Hispanic or Latino?** _____Yes _____No ___Decline to Answer	**2. Preferred Language** ___English ___Spanish ___German ___Russian ___Arabic Other_____
	3. Which category best describes your race? ___White ___American Indian or Alaska Native ___Black or African American ___ Native Hawaiian or Other Pacific Islander ___Other ___Decline to Answer	

PLEASE HAVE YOUR INSURANCE CARD(S) READY FOR US TO MAKE A COPY.

	CONSENT AGREEMENTS--PLEASE INITIAL	Initial
1	*I understand that I am responsible for charges not covered or reimbursed by my insurance. I agree, in the event of non-payment, to assume the costs for interest, collection and legal action (if required).*	
2	*I hereby assign all medical benefits to include major medical Medicare, private insurance, and any other health plans to CAPITAL CARDIOLOGY ASSOCIATE, P.C.. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.*	
3	*I understand that I have a right to request and receive a Notice of Privacy Practices from Capital Cardiology Associates, P.C.*	
4	*I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hearby authorize Capital Cardiology Associates to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit and view as necessary for my care and treatment.*	

Signature/Patient Date

Parent/Guardian Date