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 Robert J. Doria, M.D., F.A.C.C.

Today's Date:	Primary Care MD	<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Update
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PATIENT INFORMATION - PLEASE PRINT

FULL LEGAL NAME (FIRST) (MIDDLE) (LAST)			NAME NORMALLY USED (NICKNAME)	
REQUIRED - STREET ADDRESS (NUMBER) (STREET) (APT #) (SPACE #)				
PO BOX ADDRESS (NUMBER) (STREET) (APT #) (SPACE #)				
CITY	STATE	ZIP CODE	SOCIAL SECURITY #	HOME PHONE #
EMAIL ADDRESS:				CELL PHONE #
DATE OF BIRTH (MO/DAY/YR)	AGE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	OCCUPATION
EMPLOYER NAME		EMPLOYER STREET ADDRESS (CITY) (STATE) (ZIP CODE)		
BUSINESS PHONE	EXTENSION	YOUR DRIVER'S LICENSE#	STATE	

SPOUSE'S, PARENT'S, AND/OR GUARANTOR'S INFORMATION

FULL LEGAL NAME (FIRST) (MIDDLE) (LAST)			OCCUPATION	
ADDRESS (IF DIFFERENT THAN ABOVE) (CITY) (STATE) (ZIP CODE)			HOME PHONE	
EMPLOYER (STREET ADDRESS) (CITY) (STATE) (ZIP CODE)	BUSINESS PHONE		EXTENSION	

CONCERNING INSURANCE

MARK HERE IF <input type="checkbox"/> SPOUSE IS POLICY HOLDER <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDI-CAL <input type="checkbox"/> HMO <input type="checkbox"/> WORK COMP DATE OF INJURY _____				
PRIMARY INSURANCE CO. HERE	GROUP NUMBER	ID NUMBER		
INSURED'S NAME	DATE OF BIRTH	INSURANCE CO. ADDRESS		
SECONDARY INSURANCE CO. NAME	GROUP NUMBER	ID NUMBER		
INSURED'S NAME	DATE OF BIRTH	INSURANCE COL ADDRESS		

EMERGENCY INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY (NOT LIVING WITH YOU)			RELATIONSHIP
ADDRESS (NUMBER) (STREET) (APT #) (SPACE #)			
CITY	STATE	ZIP CODE	HOME PHONE

PAYMENT OF SERVICES, INSURANCE BENEFITS, AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize **Coastal Cardiology, A Medical Corporation** to obtain any medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any medical records concerning my care to any physician, hospital or other health care professional providing care to me. Additionally, I authorize the Practice to release any medical records concerning my care to my medical insurance company (i.e. Medicare, Medicaid, any insurance company, third party administrator, or managed care company) except as specifically provided below _____.

I am aware that the records may contain information relating to psychiatric or psychological testing, physical abuse and/or alcohol abuse and/or HIV test results if any.

I realize that I am responsible for payment of all medical service rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier. If I am not eligible or services rendered are not covered benefits under the terms of my employers Medical and Hospital Subscriber Agreement, I am liable for all charges for services rendered.

Patient Signature _____ Date _____

By refusing to sign the above, I understand that my insurance company will not be billed by Coastal Cardiology and I am responsible for payment at the time of service.

Patient Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize the Practice to release verbally and/or photo copies of any or all medical and billing information, pertaining to my medical care, to the following individuals: I understand this information may only be released to the individual after proper identification has been presented to the business office. The authorized person may be requested to obtain this information by appearing in person at the business office.

I do **not** authorize the Practice to release any or all information concerning my medical care to any individual except as set forth above.

I authorize the Practice to release verbally and/or photo copies of any or all information concerning my medical care to the following individuals:

Name _____ Relationship to Patient _____ DOB _____

PRINT NAME _____ PHONE # _____

Name _____ Relationship to Patient _____ DOB _____

PRINT NAME _____ PHONE # _____

Patient Signature _____ Date _____

Witness _____ Date _____

Patient's Account Number: _____ ***Unique Identification** _____