## Patient Information Sheet

********Please Complete Everything********

Patient Name_____________________________________D.O.B.____/____/____Age_______

Social Security #______-______-______ Pharmacy and location:________________________

Race:__________________ Ethnicity:__________________

Do you smoke? Yes / No Have you ever smoked? Yes / No If yes, when did you quit? _________

Date of Last Flu Shot: __________ Date Of Pneumonia Vaccine:___________

Email Address:______________________________________

Current Home Address:_____________________________________________________________

City________________________State_________Zip__________ Marital Status: ___________

Phone (____)_____________ Work (____)_______________ Cell (____)___________________

Patient's Employer___________________________________Occupation__________________

Address___________________________________________Work Phone(____)______________

Spouse's Full Name__________________________ SS#_____-____-______ DOB ___/___/____

Spouse's Employer____________________________________Occupation__________________

Referring Physician_____________________________________Phone(____)_______________

Primary Care Physician__________________________________Phone(____)_______________

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name________________________________________________Relationship_______________

Address______________________________________________Phone(____)_______________

**MEDICATION ALLERGIES:**

_________________________________________________________________________________

Please sign next page…

**RESPONSIBLE PARTY FOR PAYMENT**

I hereby agree to pay for services when charges are incurred, unless previous arrangements have been made. In the event of default, I agree to pay any collection costs and/or attorney fees as may be required to effect collection of charges incurred.

**AUTHORIZATION**

I hereby authorize Doylestown Health – The Heart Institute to release any information acquired in the course of my examination or treatment.

I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history and treatment to Doylestown Health – The Heart Institute.

I hereby authorize photocopies of this form and my signature to be as valid as the original.

I hereby authorize payment directly to Doylestown Health – The Heart Institute for the surgical and/or medical benefits, if any, otherwise payable to me under terms of my insurance.

I hereby authorize my photograph to be taken and used as part of the medical record.

**PATIENT WAVIER**

If eligibility of insurance cannot be verified, or if deductible has not been met, I understand that I will be responsible for the cost of all medical services rendered.

Patient/Legal Guardian Signature____________________________________Date_____/_____/_____

*******MEDICARE PATIENTS ONLY*******

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Doylestown Health – The Heart Institute for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.
I hereby authorize photocopies of this authorization any my signature to be as valid as the original.

Patient Signature________________________________________________Date_____/_____/_____

**HIPAA CONSENT**

I acknowledge that I have received and/or reviewed a copy of the office's Notice of Privacy Practices.

Patient/Legal Guardian Signature___________________________________Date______/______/_____

Printed Name if signed on behalf of the patient_______________________Relationship____________