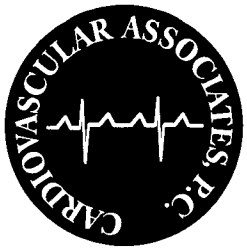

CARDIOVASCULAR ASSOCIATES, P.C.

HEART, CHEST AND VASCULAR SURGERY

MICHAEL E. DAMRICH, M.D., F.A.C.S. • CARL MALTESE, M.D., F.A.C.S. • RONALD B. O'GORMAN, M.D., F.A.C.S.
WILLIAM R. HIGGS, M.D., F.A.C.S. • DIMITRIS K. KYRIAZIS, M.D., F.A.C.S. • DAVID H. MULL, M.D., F.A.C.S.

New Patient Information

Patient Chart#: _____ Date of Birth: _____

Patient Name: _____ Sex: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Spouse Name: _____ DOB: _____

Alternate #: _____ Spouse Employer: _____

Employer: _____ Spouse Employer Phone #: _____

Employer Phone #: _____ Emergency Contact Besides Spouse: _____

Referring Physician: _____ Emergency Contact Telephone #: _____

Cardiologist: _____ Family Physician: _____

Insurance Information

Primary	Secondary
Insurance: _____	Insurance: _____
Insured Name: _____	Insured Name: _____
DOB: _____	DOB: _____
Contract Number: _____	Contract Number: _____
Group Number: _____	Group Number: _____

My office copay is $ _____. All copays are due for today's office visit.

Permission for release of Medical Records, Assignment of Benefits, and Acceptance of Financial Responsibility.

I authorize direct payment to Cardiovascular Associates, the basic and/or major medical benefits, but not to exceed the balance due of the physician's regular charges for these services. I understand that I am responsible for all charges incurred. I agree to pay any and all fees left unpaid by my insurance company. I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of individual rights.

Patient's Signature: _____ **Date:** _____

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