



Columbia Heart
Experience. Compassion. Excellence.

Patient Acct # _____ Physician: _____ Date: _____

Patient Information

Last Name		First	Middle Initial	Date of Birth	Social Security #	Marital Status	Gender
Address				City, State, & Zip Code		Home Phone #	
Patient's Employer		Work Phone #		Cell Phone #	Emergency Contact	Relationship	Phone #
Referring Physician				E-mail address			

Insurance Information (please give your insurance card to the receptionist)

Primary Insurance		Secondary Insurance	
Insured's Name	Relationship to Patient	Insured's Name	Relationship to Patient
Social Security # of Insured		Social Security # of Insured	
Date of Birth of Insured		Date of Birth of Insured	
Insured's Employer		Insured's Employer	
Policy Number		Policy Number	

Release of Information

I hereby consent to Columbia Heart's use and disclosure of any medical information concerning me that is necessary for my treatment, for Columbia Heart to secure payment for its services rendered to me, and for other healthcare business operations. Such uses and disclosures may include releasing information requested by my insurance company, other physician's offices, hospitals or workers compensation insurers. I also consent to Columbia Heart obtaining medical information from other physician's offices and hospitals such as necessary for it to provide services to me.

Insurance Assignment

I hereby assign to the physicians of Columbia Heart all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. I certify that all information provided here is correct to the best of my knowledge.

Signature of Patient _____ Date _____