

Cardiovascular Institute of Michigan, P.C.

Demographics

Patient Name: _____ **Male/ Female**
(circle one)

Address: _____ **Is there another address where**
_____ **where you reside? Yes/ No**

Phone: (____) _____ **Cell #/ Alternate:**(____) _____

E-mail Address: _____

Social Security #: _____ **Date of Birth:** ____/____/____
(Month/ Day/ Year)

Primary Language: English or _____.

Marital Status: _____ Single _____ Married _____ Divorced _____ Widow _____ Significant Other

Spouse Name _____ **Spouse's Date of Birth** _____

Spouse Social Security #: _____

Employer: _____ **Phone#** (____) _____

Occupation/ Description: _____

Primary Care Physician: _____ **Phone#:**(____) _____

Pharmacy: _____ **City:** _____ **Phone:** (____) _____

Emergency Contact: Name: _____

Phone#: (____) _____ Relationship: _____

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Cardiovascular Institute of Michigan, P.C. the insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents.

Signature: _____ **Date:** _____

Responsible Party: _____ **Date:** _____