LESLIE E. MEZEI, MD, FACC

PATIENT INFORMATION FORM

Todays' Date:_____

Name:_____ Male / Female Race:_____
(First) (Middle) (Last) (circle one)

Address :_____

City:_____ State: _____ Zip Code: _____

Phone #: Home: _____ Work: _____ Mobile:_____

Birthdate: _____ Age: _____ SSN: _____ Marital Status: _____

Employer: _____ Full / Part Time Occupation: _____
(circle one)

Emergency Contact Name: _____ Relationship:_____ Phone #: _____

Spouse's Name: _____ SSN: _____

Hospital Preference: _____ **Pharmacy Name/Address**: _____

Pharmacy Phone #: _____ **Pharmacy Fax #**: _____

Primary Care / Referring Physician: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Effective Date: _____

Policy #: _____ Group #: _____

Subscriber/Card Holder: _____Group Name: _____

(List Only if Covered by Secondary Insurance)

Secondary Insurance: _____ Effective Date: _____

Policy #: _____ Group #: _____

Subscriber/Card Holder: _____ Group Name: _____

PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST FOR PHOTOCOPYING FOR OUR RECORDS

Signature: _____ **Date:** _____

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. IT IS YOUR RESPONSIBILITY TO PAY AND CO-PAYMENTS, DEDUCTIBLE AMOUNTS, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE CARRIER.

Signature: _____ **Date:** _____

I AUTHORIZE PREMIER HEART GROUP TO RELEASE MEDICAL INFORMATION PERTAINING TO MY TREATMENT TO MY INSURANCE COMPANY, ATTORNEY AND/OR WORKMAN'S COMPENSATION CARRIER.

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