PATIENT INFORMATION:

NAME _____ DATE _____

HOME ADDRESS _____ HOME PHONE _____

CITY, STATE, ZIP _____ CELL PHONE _____

SEX _____ AGE _____ DATE OF BIRTH _____ MARITAL STATUS _____

DRIVER'S LICENSE _____ SOCIAL SECURITY # _____

EMPLOYER'S NAME AND ADDRESS _____

EMPLOYER'S PHONE NUMBER _____ OCCUPATION _____

PRIMARY CARE PHYSICIAN_____ RACE: WHITE BLACK HISPANIC ASIAN OTHER

SPOUSE'S NAME _____ SPOUSE'S CELL PHONE _____

SPOUSE'S EMPLOYER _____ SPOUSE'S EMPLOYER # _____

OUT OF STATE ADDRESS _____

OUT OF STATE PHONE NUMBER _____

EMERGENCY CONTACT:

NAME _____RELATIONSHIP _____

ADDRESS _____ PHONE NUMBER _____

REFERRED BY:

Internet____ Radio _____ Friend _____ Physician _____ Other _____

INSURANCE INFORMATION (PROVIDE COPY OF ALL CARDS)

PRIMARY CARRIER _____ SECONDARY CARRIER _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO LAKEWOOD CARDIOVASCULAR. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO LAKEWOOD CARDIOVASCULAR, MY INSURANCE CARRIER, OTHER TREATING PHYSICIANS, MY ATTORNEY, IN REPONSE TO A SUBPOENA DUCES TETUM OR TO MY REPRESENTATIVE.

SIGNATURE _____ DATE _____