

BARONE & CATANIA

CARDIOVASCULAR GROUP, PC PATIENT INFORMATION FORM

PATIENT DEMOGRAPHICS:

LAST NAME _____ FIRST NAME _____ M.I. _____

SOCIAL SECURITY# _____ DOB: _____ AGE _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ WORK _____

MAY WE CONTACT YOU AT WORK? Y N

PRIMARY CARE PHYSICIAN _____ PHONE NUMBER _____

INSURANCE DEMOGRAPHICS:

PRIMARY INS CO _____ ID# _____ GROUP# _____

NAME OF POLICY HOLDER _____ DOB _____ SS# _____

RELATIONSHIP TO PATIENT _____

EMPLOYMENT STATUS: **FULL TIME** **PART TIME** **NOT EMPLOYED** **RETIRED** **DISABLED**

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF EMPLOYER _____ OCCUPATION _____

SECONDARY INS CO _____ ID# _____ GROUP _____

NAME OF POLICY HOLDER _____ DOB _____ SS# _____

RELATIONSHIP TO PATIENT _____

EMPLOYMENT STATUS: **FULL TIME** **PART TIME** **NOT EMPLOYED** **RETIRED** **DISABLED**

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF EMPLOYER _____ OCCUPATION _____

HIPAA- ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HEREBY GIVE THE FOLLOWING PEOPLE PERMISSION TO RECEIVE INFORMATION FROM THIS OFFICE ON MY BEHALF:

NAME _____ RELATIONSHIP _____ PHONE# _____

NAME _____ RELATIONSHIP _____ PHONE# _____

X

PATIENT SIGNATURE

DATE

Patient Name: _____

Date of Birth: _____

*As part of the registration process, we are required to ask the information below.
Please circle what Ethnic Origin, Race and Language applies to you.
Thank you.*

<u>RACE</u>	<u>ETHNIC ORIGIN</u>	<u>PRIMARY LANGUAGE</u>
OTHER RACES	NON- HISPANIC	ENGLISH
WHITE	MEXICAN	SPANISH
BLACK	PUERTO RICAN	ARABIC
CHINESE	CUBAN	CHINESE
JAPANESE	CENTRAL/ S AMERICAN	FRENCH
HAWAIIAN	OTHER HISPANIC	GERMAN
FILIPINO	DECLINED TO ANSWER	GREEK
OTH ASIAN PACIFIC		HINDI
ISLAND		ITALIAN
UNKNOWN		JAPANESE
KOREAN		KOREAN
OTH PACIFIC ISLANDER		POLISH
DECLINED TO ANSWER		PORTUGUESE
MULTI WHITE BLACK		RUSSIAN
MULTI WHITE INDIAN		OTHER LANGUAGE
MULTI WHITE ASIAN		
MULTI BLACK INDIAN		

Please circle your status below.

Marital Status:

Single Married Separated Divorced Widowed Life Partner

Employment Status:

Full Time Part Time Self Employed Not Employed Retired Active Military Duty

What is your occupation? : _____

Phone: _____ **Email:** _____