Bluegrass Cardiology Consultants

Welcome to our office!

Thank you in advance for completing these 4 pages of paperwork
in order to file insurance and maintain HIPAA compliance we must have complete and accurate information

PLEASE PRINT so we can enter correct information into the computer

PATIENT INFORMATION

Patient's Name: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. First: Last:	Sex M ☐ F ☐	Date of Birth _____/_____/_____	Social Security Number

Address:	City:	State:	Zip Code:

Daytime Phone: ( )	Cell Phone: ( )	Evening Phone: ( )

E-Mail Address (this will **ONLY** be used to send you a survey about your visit today)

Employer:	Business Phone: ( )

Emergency Contact Name:	Daytime Emergency Phone Number: ( )

Primary Care Physician: (include address and phone)	Referred By:

INSURANCE INFORMATION

Primary Insurance Company:	Secondary Insurance Company (if applicable):

Complete below ONLY if the subscriber of the insurance is NOT the patient.

Subscriber Name (**if not the patient**):	Phone Number: ( )	Relationship to Patient:

Subscriber Mailing Address: State: Zip Code:
City:

Subscriber Date of Birth: _____/_____/_____	Sex M ☐ F ☐	Subscriber Social Security Number:	Subscriber Employer:

Thank you for choosing us as your cardiology provider.