PEDIATRIC CARDIOLOGY ASSOCIATES, LLC

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www.pcacny.com

Patient Name_____Birthdate_____Sex_____

Address_____ Phone _____

City, State, Zip Code_____ SS# _____

Pediatrician/Family Physician or Obstetrician_____

Parent/Guardian_____Birthdate_____ Sex_____

Address_____ Phone _____

City, State, Zip Code_____ SS# _____

Preferred Email address for Patient Portal:_____

Parent/Guardian_____Birthdate_____ Sex_____

Address_____Phone _____

City, State, Zip Code_____SS# _____

Primary Insurance Name_____ID#_____

Policy Holder_____Date of Birth_____

Relationship to Patient_____

Secondary Insurance Name_____ID#_____

Policy Holder_____Date of Birth_____

Relationship to Patient_____

Can we leave a message on voicemail with the phone numbers you supplied us with? YES _____ NO _____

OTHER PEOPLE YOU AUTHORIZE US TO SHARE MEDICAL/APPOINTMENT INFORMATION WITH:

Name Relationship Phone

_____

_____

I, the patient or guarantor, authorize treatment of the person named above and certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize the physician and practice to release any information to process insurance claims. I also authorize claims to be paid directly to the practice or its representative.

Patient/Guarantor Signature_____**Date**_____

Print Name_____**Relationship to Patient**_____