Patient Demographic Form

Please PRINT

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Email Address (Required)** | **Gender** ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other | **Language** ☐ English ☐ Spanish

Ethnicity
☐ Hispanic ☐ Non-Hispanic ☐ Other: _____

Race ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Other

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Cell Phone** | **Contact Preference** ☐ Cell ☐ Home ☐ Email

Employer | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

Preferred Pharmacy | **Preferred Lab**

PRIMARY/SECONDARY INSURANCE INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name | **First Name** | **Middle Initial**

PRIMARY Insurance Plan Name: | **Member ID#**

SECONDARY Insurance Plan Name: | **Member ID#**

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVER'S LICENSE TO OUR FRONT DESK STAFF

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Home Phone | **Cell Phone**

ANNUAL CONSENT/AUTHORIZATIONS

PATIENT NAME	DATE OF BIRTH

Consent for Treatment: I consent to the rendering of medical treatment/services as considered necessary and appropriate by the Physician, Physician Assistant, Nurse Practitioner or designated staff. The consent to receive medical treatment/services includes but is not limited to: initial evaluations, assessment evaluations, examination (EKG or otherwise), laboratory services/procedures, medications, patient education, and other services in which patient will receive. I hereby authorize my physician or designated staff to perform diagnostic studies, as a recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. Diagnostic testing and services may include but is not limited to: echocardiograms, carotid ultrasounds, exercise tread mill test, nuclear stress test, ABI, post exercise ABI, holter/event monitor and other services recommended by your physician. I am aware that there may be material risk associated with these procedures. If I have any questions or concerns regarding any procedure, I will ask my physician to provide me with additional information.

I understand I have the right to see a Physician if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by a Physician Assistant or Nurse Practitioner.

I give my consent to have Gainesville Heart & Vascular Group obtain my prescription history from external sources. _____ **(Initials)**

Consent to Release Medical Information to a Spouse, Family Member or Significant Other

I hereby authorize Gainesville Heart & Vascular Group to release and/or discuss any information contained in my medical record to the person or persons listed:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

☐ I do NOT authorize any information to be released to anyone other than myself.

I give permission for you to leave medical/appointment information for me via the following sources:

☐ Home Phone ☐ Cell Phone ☐ Text Message ☐ Email ☐ Other _____

FINANCIAL RESPONSIBILITY

I understand that it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid to Gainesville Heart & Vascular Group and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE