

SANDHILLS CARDIOLOGY, P.C.

Welcome to our practice. Please complete the following form as completely as possible so that we may establish your patient record. Thank You.

Patient Name _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone Number: _____ Work Telephone Number: _____

Date of Birth: _____ Sex: _____ Married: _____ Single: _____

Social Security Number _____ Employer: _____

Primary Care Physician: _____ Referring Physician: _____

Insurance Information

Name of insured: _____

Relationship to Patient: Self(), Spouse (), Parent or legal guardian () please check one

Insurance Company Name: _____

Insurance Company address & phone#: (we need copy of insurance card):

Insured's Address:

City: _____ State: _____ Zip: _____

Home Telephone Number: _____ Work Telephone Number: _____

Social Security Number _____ Employer: _____

We only discuss medical or billing information with your permission. Please indicate whom, other than yourself we are allowed to release or discuss information to, their relationship to you and what information we can discuss with them.

Name Relationship to patient MEDICAL / BILLING
please circle

Name Relationship to patient MEDICAL / BILLING
please circle

Patient's signature or legal guardian: _____

Date Signed: _____

Please fill in all relevant information on these forms (except for your social security number) **before** your first visit to either one of our offices.

For added security we advise that you **DO NOT FILL IN YOUR SOCIAL SECURITY NUMBER** until you get to our offices.