PATIENT INFORMATION________________________(PLEASE PRINT)

Patient's Name: (Last)________________________(First)____________________(MI)__________

DOB:_____/_____/_______ Marital Status:________________________________

Address:____

City:________________________State:______________________Zip:____________

Home #________________________________Cell #____

Work #________________________________ Employer:____________________________________

Email address:____

Best time to contact (circle one) Morning Afternoon

Do you have a []Pacemaker []Defibrillator []Implantable Loop Recorder Brand____________________

Sex: []Female []Male []Transgender Preferred Pronouns:_____________________

Race: []American Indian/Alaska Native []Native Hawaiian/Pacific Islander

[]Black/African American []White []Hispanic []Other____________________ []Declined

Ethnicity: []Hispanic or Latino []Not Hispanic or Latino []Other______________ []Declined

Language: []English []Spanish []Indian []Japanese []Chinese []Korean []Other________

EMERGENCY CONTACT INFORMATION____

Emergency contact name:(Last)______________________________(First)______________________

Phone #____ Relationship:_____________________

RESPONSIBLE PARTY INFORMATION (IF NOT SELF)___(Information used for patient balance statements)

Responsible Party: []Self []Guarantor []Another Patient

[]Check here if address and telephone information is same as patient

Responsible party name:(Last)_____________________________(First)_________________________

DOB:_____/_____/________ Sex: []Female []Male

Phone #____Work #___________________________

Address:____

City:___________________________________State:________________________Zip:___________

HEALTH INSURANCE INFORMATION____

Primary Insurance:____

Claims mailing address:_________________________________ Phone#________________________

Member ID:___________________________________ Group Number:________________________

Secondary Insurance:____

Claims mailing address:_________________________________ Phone#________________________

Member ID:___________________________________ Group Number:________________________

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, your are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other healthcare providers or the designs as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to it contents.

Signature of patient or personal representative:____

Printed name of patient or personal representative:____

Relationship to patient:____Date:________________________