

**LOUISVILLE CARDIOLOGY MEDICAL GROUP, PSC.
SIGN-IN SHEET**

PATIENT INFORMATION

First Name _____ Initial _____ Last _____
Street Address _____ City _____ ST _____ Zip _____
Home Phone _____ Cell Phone _____
Social Security # _____ Age _____
Date of Birth _____ Sex _____ Marital Status _____ Spouse's Name _____

REFERRING PHYSICIAN _____ Family Physician _____

EMERGENCY CONTACT

| EMERGENCY CONTACT | RESPONSIBLE PARTY (IF DIFFERENT) |
|-------------------------------|----------------------------------|
| Emergency Name _____ | Emergency Name _____ |
| Street Address _____ | Street Address _____ |
| City _____ ST _____ Zip _____ | City _____ ST _____ Zip _____ |
| Home Phone # _____ | Home Phone # _____ |

EMPLOYER INFORMATION

| | |
|----------------|----------------------|
| Employer _____ | Street Address _____ |
| City _____ | Work Phone # _____ |

PRIMARY INSURANCE

INSURANCE COMPANY NAME _____
ADDRESS _____
SUBSCRIBER _____
GROUP NUMBER _____
SUBSCRIBER SS# _____
SUBSCRIBER D.O.B. _____

SECONDARY INSURANCE

INSURANCE COMPANY NAME _____
ADDRESS _____
SUBSCRIBER _____
GROUP NUMBER _____
SUBSCRIBER SS# _____
SUBSCRIBER D.O.B. _____

ATTACH COPY OF FRONT & BACK OF INSURANCE CARD ON SEPARATE SHEET

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby authorize examination and any other medical services deemed necessary by my physician. I, the undersigned, authorize payment of medical benefits to my physician for any services furnished to me. I understand I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company all information concerning healthcare, advice, treatment, or supplies provided to me. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits payable for related services.

PATIENT SIGNATURE _____ DATE _____