

J. Feiner, M.D.
D. Lyle, M.D.
R. Masters, M.D.
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South Orange County Cardiology Group

Patient Information Sheet

D. LaMont, M.D.
H. Frumin, M.D.
R. Gim, M.D.

Patient Name _____ Age _____ M F
Last First MI

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Marital Status _____

Phone 1 _____ Home Cell Work Phone 2 _____ Home Cell Work

Employer _____ E-mail _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Driver Lic# _____ Referred By: _____

Emergency Information

Spouse's Name _____ DOB _____

Phone 1 _____ Home Cell Work Phone 2 _____ Home Cell Work

Relationship _____ Phone _____ Home Cell Work

Primary Insurance Information

Insurance Company Name _____ Group# _____

Date of Birth of Insured _____ Policy/ID# _____

Billing Address _____ City _____ State _____ Zip _____

Name of Insured _____ Relationship to Patient _____

Secondary Insurance Information

Insurance Company Name _____ Group# _____

Date of Birth of Insured _____ Policy/ID# _____

Billing Address _____ City _____ State _____ Zip _____

Name of Insured _____ Relationship to Patient _____

I authorize doctor or his assistant to leave confirmation messages concerning appointments or lab results on my answering machine.
Yes No I further authorize doctor or his assistant to leave message with _____.

I hereby authorize Dr. _____ to furnish the above insurance company(s) or a designated attorney all information which said insurance company(s)/attorney may request. I authorize the release of medication information necessary to process my claims. I authorize payment of medical benefits for services rendered by this group. I agree, in the event of no payment, to bear the cost of collection and/or cost and reasonable legal fees should this be required.

I understand that I am financially responsible for charges when services are rendered to me and that payment for services is expected at the time they are rendered. I further understand that despite the fact that Medicare or my private insurance carrier may not reimburse me for these services, I am financially responsible. In the event that Medicare denies payment, I may appeal the decision to Medicare. **If lab work is ordered and Medicare denies payment, I agree to be personally responsible for payment or I may appeal decision to Medicare.**

Patient's Signature _____ Date _____