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<http://www.swcardiology.com>

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female  
Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

### Primary Insurance

Same as the patient information – patient is the Primary insurance subscriber  
Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_  
Subscriber Employer: \_\_\_\_\_ Subscriber Gender:  Male  Female

### Secondary Insurance

Same as the patient information – patient is the Secondary insurance subscriber  
Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_  
Subscriber Employer: \_\_\_\_\_ Subscriber Gender:  Male  Female

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to Southwest Cardiology, Inc. to render needed treatment to the above named patient.
2. I authorize Southwest Cardiology Inc to release any Information required for payment of claims.
3. I authorize payment of medical benefits to Southwest Cardiology Inc for services rendered.
4. I understand that I AM RESPONSIBLE for all charges incurred through Southwest Cardiology, Inc. Payment is expected at the time of my visit. If this cannot be done, I agree to pay any collection or attorney's fees incurred above and beyond the past due amount.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_