

Face Sheet (Standard)

Please answer all questions fully

Date:

Account Number:

Central Bucks Cardiology

315 West State Street
Doylestown, PA 18901

Phone: (215) 345-1900 Fax: (215) 345-4579

Patient					
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Home Phone
					Cell Phone
Mailing Address	City	State	Zip Code	Marital Status	
Employer	City	State	Zip Code	Work Phone	

Responsible Party					
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Home Phone
Address	City	State	Zip Code	Marital Status	
Employer	City	State	Zip Code	Work Phone	

Primary Provider	Address	Phone	Fax

Insurance Information					
Primary Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group #	Co-pay	
Second Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group #	Co-pay	
Third Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group #	Co-pay	

Emergency Contact Information			
Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

Please List Medications

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: _____
(Signature of insured or authorized person, patient, or parent if minor)

Date: _____