# SUN STATE CARDIOLOGY

**60 N. McClintock Dr., Suite 3**
**Chandler, AZ 85226**
**(480) 821-3800**
**FAX (480) 821-3806**

Today's date _____

Name _____ Birth Date _____ Age _____
Last First MI

Local Address_____ City _____State _____ Zip _____

Permanent Address _____City _____ State _____ Zip _____

Sex: F M Marital Status: S M D W Social Security Number: _____ Home phone _____

Name of Spouse: _____ Spouse Social Security #: _____ Mess. # _____

Who referred you to this office?_____ Phone _____

Name of employer _____ Work Phone _____

Employer's address _____ City _____ State _____ Zip ---_____

In an emergency whom would we notify? _____ Phone _____

**Primary Insurance Company_____**

Name of insured _____ Date of Birth _____ Spouse ____ Parent ___

Address _____ City _____ State _____ Zip _____

Phone Number _____ GROUP NAME _____

I.D. NUMBER _____ GROUP NUMBER_____

**Secondary Insurance Company** _____

Name of insured _____ Date of Birth _____ Spouse ____ Parent _____

Address _____ City _____ State _____ Zip _____

Phone # _____ _____ GROUP NAME _____GROUP NUMBER_____

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AUTHORIZATION RELEASE INFORMATION: "I AGREE THIS OFFICE MAY RELEASE RECORDS PERTAINING TO MY TREATMENT TO MY INSURANCE COMPANY OR OTHER THIRD PARTIES RESPONSIBLE FOR PAYMENT OF MY MEDICAL CHANRGES INCLUDING REVIEW ACTIVITIES RELATED TO MY PHYSICIAN'S PARTICIPATION WITH MY HEALTH PLAN." AUTHORIZATION TO PAY: I UNDERSTAND THAT PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE RENDERED, ULESS CHARGES ARE SUBMITTED TO A PARTICIPATING INSURANCE PLAN, I HEAREBY AUTHORIZE PAYMENT DIRECTLY TO **Sun State Cardiology, PC** FOR THE SURGICAL AND/OR MEDICAL BENEFITS OTHERWISE PAYABLE TO ME FOR SERVISES PROVIDED TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE. IF I AM BILLED FOR ANY NON-COVERED OR CO-INSURANCE AMOUNTS, I WILL PAY CHARGES WITHIN 10 DAYS OF BILLING DATE UNLESS PRIOR ARRANGEMENTS ARE MADE.

I HAVE READ THE ABOVE STATEMENTS REGARDING FEES AND RELEASE OF INFORMATION AND AGREE TO THE TERMS AND CONDITIONS SET FORTH.

_____ _____

**PATIENT'S SIGNATURE** **DATE**