

# MARYLAND PEDIATRIC CARDIOLOGY CENTER, LLC

## NEW PATIENT INFORMATION

(Please Print Clearly)

Today's Date: \_\_\_\_\_

### Patient Information

Last Name	First Name	MI	Patient's Social Security Number
Address (Street)			D.O.B of patient (Male/Female)
City	State	Zip	Patient's Home Phone#
Cell Phone /Work Phone (Ext)			Email Address
Emergency Contact Name			Emergency Contact Phone #
Primary Care Physician Name			Primary Care Physician Phone #
Reason for Today's Visit			Referring Physician Name if Applicable

### Insurance Information

Primary Insurance Company Name	Policy ID #	Group#
Policy Holder's Name & D.O.B	Relationship to Patient	
Policy Holder's Employer	Co-Pay Amount	
Secondary Insurance Company Name	Policy ID#	Group#
Policy Holder's Name DOB	Relationship to Patient	
Policy Holder's Employer	Co-Pay Amount	

### Guarantor Information (For Minors)

Guarantor's Name (Any Parent Information)	SSN
Address (Street)	Home Phone
City State Zip	Work Phone

**Patient's Authorization.** I authorize MD Pediatric Cardiology Center to apply for benefits on my behalf for services rendered by MD Pediatric Cardiology Center. I request payment from my insurance company be made directly to MD Pediatric Cardiology Center. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of my primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Patient (or Minor Patient's Representative) Signature	Date
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