

New Patient Questionnaire

Please answer all of the questions completely

Name: _____ Second Address: _____
Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____

Primary Care Provider: _____

Referring Physician: _____

Date of Birth: _____ Marital Status: S M W D Gender: _____

Ethnicity: _____ Race: _____ Religion: _____

Social Security # _____ Preferred Language _____

Level of Education _____

Employment Status: Full Time Part Time Unemployed Student

Occupation: _____

Employer Name: _____

Preferred Pharmacy: _____

Primary Insurance Carrier: _____

Name of Insured: _____

Patient's Relation to Insured: _____

Policy #: _____ Group#: _____

Secondary Insurance Carrier: _____

Name of Insured: _____

Patient's Relation to Insured: _____

Policy #: _____ Group#: _____

Reason for Visit: _____

Emergency Contact (name, relation & phone number) _____

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company. I allow fax transmittal of my medical records. I acknowledge full responsibility for services rendered by Hopkins Cardiovascular Associates. I understand payment of charges incurred is due at the time of service unless other financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Jordan E. Hopkins, MD FACC/Hopkins Cardiovascular Associates LLC should they elect to receive such payment. I have read fully and understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature: _____ Date: _____