Health ONE Cardiothoracic Surgery Associates
Physician Care℠

Patient Name: Last _____ First _____ MI _____ **Prefer to be called:** _____

Address: _____ **APT#** _____**City** _____ **ST** ____ **ZIP** _____

Home Phone: _____ **Cell**: _____ **Work**: _____ **SSN**: _____

Employer: _____**Occupation**: _____ **Email**:_____

DOB: ___/___/___ **Sex**: M__F __Transgender __ **Marital Status**: S__ M__ D __ W __ Legally separated __ Partner__

Race: American Indian/Alaska Native__ Asian__ Native Hawaiian/Pacific Islander__ Black or African American__

White__ Declined to name__ **Ethnicity:** Hispanic or Latino__ Not Hispanic or Latino__ Declined__

Primary Language Spoken (other than English): _____ **Do you have a living will** Yes___ No____

New Patients to the Practice: Who may we thank for your referral to our practice?
Dr: _____ Family member ___Friend___Insurance directory___ Other _____

Pharmacy Name and Phone Number_____

PRIMARY INSURANCE: _____ **Eff Date:** _____ **Copay amount:**_____

Policy Holder Name: _____ DOB: __/__/__ Male__ Female__

Policy Holder address if different from above: _____

Policy Holder Employer: _____ Employer Phone #: _____

Relationship to Policy Holder: _____ Policy Holder SSN: _____

Policy ID Number: _____ Group Number: _____

SECONDARY INSURANCE: _____ **Eff Date:** _____

Policy Holder Name: _____ DOB: __/__/__ Male__ Female__

Policy Holder address if different from above: _____

Policy Holder Employer: _____ Employer Phone #: _____

Relationship to Policy Holder: _____ Policy Holder SSN: _____

Policy ID Number: _____ Group Number: _____

EMERGENCY CONTACT NAME: _____ **Relationship to patient**: _____

Contact phone number: _____ **Alt #:** _____

Patient/Responsible Party Signature _____ **Date:** _____