

PATIENT INFORMATION

Please print clearly, or type into this form on your computer before printing it.

ABOUT YOU

Last name		First name		Middle initial	Preferred name	
Date of birth (MM/DD/YYYY)	Sex	Marital status				
	☐ Male ☐ Female	☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed				
Home address		Apt / unit	City	State	ZIP	
Second or seasonal address, if any		Apt / unit	City	State	ZIP	Months there
Mobile phone	Home phone	Work phone	Email			
Best way to reach you: ☐ Mobile ☐ Home ☐ Email			Text me appointment reminders: ☐ Yes ☐ No			
Employer						
☐ Retired ☐ Not employed						

RACE, ETHNICITY AND LANGUAGE Federal health programs ask us to collect this. You may choose not to answer.

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Other:

 ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Preferred language: ☐ English ☐ Spanish ☐ Other:

 Need an interpreter? ☐ Yes ☐ No

INSURANCE Please give the front desk your insurance card(s) and a photo ID to copy.

Primary insurance

Insurance company

Member ID	Group number
Policyholder name	
Policyholder date of birth	Policyholder's relationship to you

Secondary insurance

Insurance company

Member ID	Group number
Policyholder name	
Policyholder date of birth	Policyholder's relationship to you

☐ I have no insurance, or I will pay for my care myself. I know I can ask for a Good Faith Estimate of my costs.

Patient name

Date of birth

YOUR CARE TEAM AND EMERGENCY CONTACT

Primary care physician

PCP phone

Referring physician, if different

Preferred pharmacy

Pharmacy location or cross streets

Pharmacy phone

Emergency contact

Relationship to you

Phone

WHO MAY RECEIVE INFORMATION ABOUT YOUR CARE

List anyone we may speak with about your care, test results and appointments. We may ask for their date of birth to confirm who they are.

Name

Relationship to you

Date of birth

Phone

MESSAGES

May we leave detailed messages about your appointments and test results:

On your voicemail? ☐ Yes ☐ NoBy text message? ☐ Yes ☐ NoIn the patient portal or by email? ☐ Yes ☐ No**PRESCRIPTION HISTORY**

I consent to CVIS obtaining my prescription history from pharmacies and my health plan.

Your initials

ACKNOWLEDGMENT AND SIGNATURE

- I received the Cardiovascular Institute of Scottsdale Notice of Privacy Practices.
- CVIS may share my health information with other providers and facilities involved in my care, such as where my tests or procedures are scheduled.
- I may change the people listed above at any time by telling CVIS in writing.
- The information on this form is correct to the best of my knowledge.

Date

Signature of patient or legal representative

Printed name

If not the patient, relationship to patient

Signed by: ☐ Patient ☐ Parent ☐ Guardian ☐ Legal representative**OFFICE USE ONLY**Entered in chart by: _____ Date: _____ Insurance cards and photo ID scanned ☐ Yes ☐ No