IMC-Cardio Thoracic and Vascular Surgical Associates

Who is your Primary Care Physician:________________________________

What doctor referred you to our office?______________________________

Is this visit related to an Accident?
☐ No ☐ Yes date ___________

Patient Name:____ Patient Birthdate: _____/____/_______
(last) (first) (middle initial)

Patient Sex: Male Female Patient Social Security #:________/_____/________ Marital Status:_____________

Ethnicity: (circle) American Indian Black Caucasian Hispanic Non Hispanic Other

Race: (circle) American Indian Asian Black or African American Caucasian/White Hispanic Non Hispanic Other

Mailing Address or PO Box:____

City:__________________________State:________Zip:___________ E-mail:_____________________________

Home Phone:(____)_____-________ Cell:(____)_____-________ Work Phone:(______)________-__________

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Retired

Employer:____

Emergency Contact

Name:____ Relationship:_____________________________

Home Phone:(____)_____-________ Cell Phone:(____)_____-________ Work Phone:(_____)______-_________

Person responsible for any balance on this account- (only if the patient is a minor)

Name:____

Relationship:____ Birthdate: ______/______/________

Street Address:_________________________________ City:_________________ State:_____ Zip:__________

Home Phone:(____)_____-________ Cell Phone:(____)_____-________ Work Phone:(_____)______-________

Employer:______________________________

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

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Primary Insurance Information **Please complete this section only if the patient is not the policy holder**

Insurance Company:______________________________________

Name of Policy Holder/Insured:___________________________________ Insured Date of Birth:____/___/_____

Relationship to Patient:_____________ Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

Second Insurance (if applicable)

Insurance Company:______________________________________

Name of Policy Holder/Insured:___________________________________ Insured Date of Birth:____/___/_____

Relationship to Patient:______________ Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed