Telephone
(781) 331-2000

Fax
(781) 331-6075

70 Pleasant Street, South Weymouth, MA 02190

Patient Information Form

Last Name: ________________________________ First Name: ______________________ MI: _______

Street Address: ____

City: ______________________________ State: ________ Zip Code: _______________

Social Security #: ______-_____-________ Sex: ________ Date of Birth: ____/____/________

Home#: (   ) ______-________ Work#: (   ) ______-________ Cell#: (   ) ______-________

E-Mail Address: ________________________@______________________.________

Emergency Contact: ____________________________________ Phone#: (   ) ______-________

Please list any current medications:

____

____

____

Please list any medication allergies:

____

____

____

Insurance Information

Primary Physician: ____

Medical Insurance Name: _____________________________ Certificate#: _________________________

Group#: _________________________

Secondary Insurance: ________________________________ Certificate#: ________________________

Group#: _________________________

Subscriber's Name (if different from patient): ____

Subscriber's Date of Birth: ____/____/________ Social Security #: _______-_____-________

Subscriber's Employer Name: ____

Employer's Address: ____

Relationship of patient to subscriber (check one): _______ Spouse _______ Child

Signature for Authorization: _____________________________________ Date: ____/____/________

DID YOU REQUEST A REFERRAL AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN FOR THIS VISIT? (check one): ________ YES ________ NO

If your answer is NO, please sign this waiver below if you wish to be seen today.

I, the undersigned, agree to be responsible for payment of any services provided by a specialist at South Shore Cardiology PC if my primary care physician has failed to authorize a referral on my behalf.

Signature of Patient: ____ Date: ____/____/________

Disclosure Form For Medical Billing / Medical Information

I give permission to South Shore Cardiology PC to discuss my (please check):

____ Medical Billing Information and/or ____ Personal Medical Information

With the following persons (excluding physicians or other medical personnel):

____ Family Members ____ Other: ____________________________

This authorization is voluntary and may be revoked at any time by informing South Shore Cardiology PC in writing at the above address. I understand this authorization will expire:

____ Indefinitely ____ Other: ____________________________

____ I have received the "Privacy Practices" of South Shore Cardiology PC

Patient Name: ____ Date of Birth: ____/____/________

Signature of Patient: ____ Date: ____/____/________

Primary Language: ________________________________

Race: _________________________ Ethnicity: _________________________

*****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*****

PATIENT RECORD OF DISCLUSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

____ Home Telephone#: (   ) ______-________

____ OK to leave message with detailed information

____ Leave message with call-back number only

____ Work Telephone#: (   ) ______-________

____ OK to leave message with detailed information

____ Leave message with call-back number only

____ Other: ________________________________

____ Written Communication

____ OK to mail to my home address

____ OK to mail to my work/office address

Signature of Patient: ____ Date: ____/____/________

Printed Name: ______________________________________ Date of Birth: ____/____/________