# *Woods Cardiovascular Internal Medicine Associates, P.C.*

**PATIENT INFORMATION**

**DATE: _____**

| | | |
|---|---|---|
| LAST NAME, FIRST NAME, MIDDLE INITIAL: | | |
| ADDRESS: | | |
| CITY, STATE, ZIP: | | |
| HOME PHONE:(  ) | | MOBILE PHONE:(  ) |
| WORK PHONE:(  ) | GENDER: ☐M ☐F | LANGUAGE: |
| DATE OF BIRTH: | AGE: | SOC SEC NUMBER: |
| MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED | | |
| RACE: ☐BLACK/AFRICAN AMERICAN ☐ASIAN ☐WHITE ☐NATIVE HAWAIIAN/PACIFIC ISLANDER<br>☐AMERICAN INDIAN/NATIVE ALASKAN ☐OTHER_____ | | |
| ETHNICITY: ☐HISPANIC ☐NON-HISPANIC | | OCCUPATION: |
| EMAIL ADDRESS: | | CONFIRM MY APPOINTMENT VIA: ☐EMAIL ☐PHONE |
| DO YOU HAVE AN ADVANCED DIRECTIVE? ☐YES ☐NO DO YOU WANT INFORMATION ON ADVANCED DIRECTIVES? ☐YES ☐NO | | |
| REFERRING DOCTOR: | | |

**PHARMACY INFORMATION**

| | | |
|---|---|---|
| PHARMACY: | | CITY: |
| CROSS STREETS: | | PHONE NUMBER:(  ) |
| **PRIMARY INSURANCE:** | | CONTRACT# |
| SUBSCRIBER: | DOB: | GROUP# |
| RELATIONSHIP: | | EFFECTIVE DATE: |
| **SECONDARY INSURANCE:** | | CONTRACT# |
| SUBSCRIBER: | DOB: | GROUP# |
| RELATIONSHIP: | | EFFECTIVE DATE: |

IS THIS VISIT RELATED TO: ☐WORK INJURY ☐AUTO ACCIDENT ☐N/A

| | | |
|---|---|---|
| DATE OF INJURY: | STATE: | INS. COMPANY NAME: |
| CLAIM NUMBER: | BILLING ADDRESS: | |

IS IT OK TO LEAVE TEST RESULTS ON YOUR ANSWERING MACHINE OR VOICEMAIL? ☐YES ☐NO

**IN CASE OF EMERGENCY** – WHOM SHOULD WE CONTACT?

NAME: _____ PHONE #: _____

RELATIONSHIP: _____

DO YOU WANT MEDICAL HEALTH RECORD INFORMATION SHARED WITH THIS PERSON? ☐YES ☐NO

PATIENT SIGNATURE: _____ DATE: _____