



New Patient Questionnaire:

Please answer all the questions completely.

Name: \_\_\_\_\_ Second Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: S M W D

Gender \_\_\_\_\_ Ethnicity \_\_\_\_\_ Religion \_\_\_\_\_

Social Security # \_\_\_\_\_

Level of Education \_\_\_\_\_

Employment Status  Full Time  Part Time  Unemployed  Student

Occupation \_\_\_\_\_

Employer Name: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Patient's Relation to Insured: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Patient's Relation to Insured: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Reason for visit \_\_\_\_\_

Emergency Contact (name, relation & phone number) \_\_\_\_\_

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company. I allow fax transmittal of my medical records. I acknowledge full responsibility for services rendered by Aldrich Cardiovascular Institute. I understand payment of charges incurred is due at the time of service unless other financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Martin Aldrich M.D., F.A.C.C./Aldrich Cardiovascular Institute should they elect to receive such payment. I have read fully and understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_