New Patient Questionnaire:
Please answer all of the questions completely.

Name:_____ Second Address:_____
Address:_____ _____
_____ _____
_____ _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____
Email Address:_____
Primary Care Provider:_____
Referring Physician:_____
Date of Birth:_____ Marital Status: S M W D
Gender:_____ Ethnicity:_____ Race: _____ Religion:_____
Social Security #_____ Preferred Language_____
Level of Education_____
Employment Status: Full Time Part Time Unemployed Student
Occupation:_____
Employer Name:_____
Preferred Pharmacy:_____
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:_____