Northwest Cardio-Vascular Associates S.C.

PATIENT INFORMATION

Patient's Full Name: _____
(LAST) (FIRST) (MI)

Patient's Home Address: _____

_____
(CITY) (STATE) (ZIP)

Patient's Home Phone: (_____)_____ Patient's Cell Phone: (_____)_____

Patient's E-mail: _____

Patient's Date of Birth: _____/_____/_____ Age: _____ SSN#: _____/_____/_____

Primary Care Physician, Full Name: _____ Phone: (_____) _____

Patient's Status: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed

Patient's Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Unemployed

Patient's Employer's Name: _____

Patient's Employer's Address: _____

_____
(CITY) (STATE) (ZIP)

Patient's Work Phone: (_____)_____

Does the patient have insurance through this employer? ☐ Yes ☐ No

EMERGENCY CONTACT

Full Name: _____
(LAST) (FIRST) (MI)

Address: _____

_____
(CITY) (STATE) (ZIP)

Home Phone: (_____)_____

Work Phone: (_____)_____ Cell Phone: (_____)_____

HEALTH CARE REFORM QUESTIONS

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT DOCTORS ARE REQUIRED TO ASK **ALL** PATIENTS FOR THEIR RACE, ETHNICITY AND PREFERRED LANGUAGE **REGARDLESS OF YOUR INSURANCE** TO MEET MEANINGFUL USE REQUIREMENTS.

RACE:

☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian
☐ Black or African
☐ White
☐ Hispanic
☐ Other Race: _____
☐ Refused to Report

ETHNICITY:

☐ Hispanic ☐ Non-Hispanic

Preferred Language: _____