

DAYTONA HEART GROUP  
PATIENT INFORMATION

Please circle the Doctor you are going to see:

Dr. Klancke      Dr. Wilson      Dr. Rayos      Dr. Reed      Dr. Goldsmith      Dr. Seide  
Dr. Bartholomew      Dr. West      Dr. Broome-Webster      Dr. Lazard

PLEASE PRINT

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Local Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Northern Address: \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Person to notify other than spouse: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Policy or Certificate No. \_\_\_\_\_

Group No. \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policyholder's Name \_\_\_\_\_

**\*\*PLEASE PROVIDE A COPY OF YOUR INSURANCE CARDS FOR FILING OF YOUR INSURANCE. THANK YOU!**

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CERTIFICATION FOR PAYMENT FOR ALL INSURANCES

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

*I request that this authorization also apply to all other insurance.*

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT.

Signed \_\_\_\_\_ Date: \_\_\_\_\_