

Date _____

Account Data Sheet

Dear Patient: Kindly complete the data shown below for your contact information. Note especially the authorizations below for family or care takers access.

Patient _____

Doctor's Name _____

Address _____

Date of Birth _____

City, State and Zip Code _____

Social Security _____ - _____ - _____

Home Phone # _____

Marital Status S M D W
Circle one

Cell Phone # _____

Employment Status Active Disabled Retired Unemployed
Circle one

Work Number # _____

Employer if applicable _____

Email address _____

Employer City/State _____

Primary Insurance Information

Secondary Insurance Information

Insured: _____

Insured: _____

Insured DOB: _____

Insured DOB: _____

Plan Name: _____

Plan Name: _____

Policy Number: _____

Policy Number: _____

Group Number: _____

Group Number: _____

1) I hereby authorize my insurance company's (named above) to pay benefits to Winchester Cardiology and Vascular Medicine, PC for services rendered.

Patient or Subscriber Signature

2) By signing this consent form, you are granting written consent to Winchester Cardiology and Vascular Medicine, PC to provide medical treatment. You have the right to inquire to the cost and reason for any services ordered by your physician. Winchester Cardiology and Vascular Medicine has the authority to disclose your Protected Health Information (PHI) for the purposes of treatment, payment, and healthcare operations. Any other individual requests for your PHI other than "incidental", will require your signature releasing those records requested. {Such as life insurance applications, disability benefits, etc.}

3) I acknowledge receipt of Winchester Cardiology and Vascular Medicine, PC's Privacy Notice.

4) We reserve the right to purge records after 10 years of inactivity.

5) You have the right, any time, to revoke the consent in writing. Direct to Management Staff.

6) Please list any persons you would like to authorize to have access to your billing, appointment, or health information such as your spouse, caregiver, or family member:

NAME	RELATIONSHIP	PHONE
_____ Print Name	_____	_____
_____ Print Name	_____	_____
_____ Print Name	_____	_____
_____ Print Name	_____	_____

Signature or Patient/Legal Guardian

Date

Signature of Witness

Date

Print Name

Print Name