NEVADA CARDIOLOGY ASSOCIATES

BOARD CERTIFIED CARDIOLOGISTS

Foad Moazez, MD, FACC, FCCP
Samuel E. Green, MD, FACC
Patrick C. Hsu, MD, FACC
Robert L. Baker, MD, FACC
Richard Chen, MD, FACC
Navid Kazemi, MD, FACC
Vanessa G. Gastwirth, MD, FACC
Erik Sirulnick, MD, FACC
Tariq Marroush, MD, FACC
Carmel Moazez, MD

Today's date:	Primary Care Dr:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home Phone.:	Cell phone: ( )

Apt Number:	City:	State:	ZIP Code:

Occupation:	Employer:	Work Phone & ext: ( )

Race:	Ethnicity (choose one) ❑ Hispanic or Latino ❑ Not Hispanic	Language:

Ok to leave detailed message? ❑ Yes ❑ No	Email Address:	Do you have an advanced directive? Such as:

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:	Policy No:	Group no:

Subscriber's name:	Subscriber's Social Security no:	Date of Birth: / /

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

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SECONDARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:	Policy No:	Group no:
Subscriber's name:	Subscriber's Social Security no:	Date of Birth: / /

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

PHARMACY INFORMATION

Preferred Local Pharmacy:	Phone:	Fax:	Address:
Mail Order Pharmacy:	Phone:	Fax:	Address:

RELEASE OF INFORMATION

I give permission to release my medical information to the following:

Patient/Guardian signature *Date*

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Nevada Cardiology Associates to release any information that we have acquired, that is necessary to process my claims. I allow Nevada Cardiology Associates permission to view prescription history from external sources. I allow Nevada Cardiology Associates to obtain my results/records from radiology facilities, laboratory facilities, hospital facilities and any other medical providers.

Patient/Guardian signature *Date*