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WACCAMAW CARDIOLOGY, P.C.

Name _____ Date of Birth _____

Home# _____ Work # _____ Pager/Cell _____

Social Security# _____ Sex M F Marital Status S M D W

Mailing Address: _____

Street City/State Zip Code

Street Address: _____

Street City/State Zip Code

Patient's Employer: _____ Spouse's Employer _____

Referring Physician _____ Cardiologist _____

Primary Insurance Carrier _____

Is this through an employer? YES NO If yes, name of employer _____

Insured party _____ Relationship to Patient _____ D.O.B. _____

CONTACT INFORMATION:

Emergency contact:

Name Relationship Telephone/Alternate#

May we leave health information on your answering machine/voice mail? YES NO

Please list below all the people that you authorize for us to leave health information with or with your whom we may discuss your care:

Name Relationship Telephone/Alternate#

Name Relationship Telephone/Alternate#

*Please note that we reserve the right to use our professional judgment when leaving information in urgent situations where your health is deemed to be at risk.

Signed _____ Date _____