EAST BAY CARDIOVASCULAR AND THORACIC ASSOCIATES

Patient Information

Name ______________________________ ______________________________ ____________

Last First Middle

Gender M / F **Date of Birth** ______________________ **Social Security Number (SSN)** ______________________

Address ____

City ______________________________ **State** ______ **Zip Code** ______________________________

Phone Numbers - Home: ____________________ Cell: ______________________ Other: ____________________

Email Address ____

Emergency Contact

Name ____________________________ Relationship ____________________ Phone Number ________________

Name ____________________________ Relationship ____________________ Phone Number ________________

Name ____________________________ Relationship ____________________ Phone Number ________________

Primary Care Physician ___________________________ **Referring Physician** ______________________________

California Vascular Care is an affiliate of East Bay Cardiovascular and Thoracic Associates.

I certify that the information above is correct. I agree that insurance benefits for East Bay Cardiovascular and Thoracic Associates provider charges payable to the insured are made payable to East Bay Cardiovascular and Thoracic Associates and that physician benefits otherwise payable to the insured are to be made payable to East Bay Cardiovascular and Thoracic Associates. Any payments received for services rendered to me by Eastbay Cardiovascular and Thoracic Associates may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. I acknowledge that I am fully responsible for all non-covered services, deductibles and co-payments. I further agree, in the event of default due to non-payment, to be responsible for collection fees, court costs and/or legal fees.

Signature of Patient ____ **Date** __________________________