



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 _____