Capital Cardiology Associates
CARING FROM THE HEART | A BENCHMARK CARDIOLOGY PRACTICE℠

AFFIX LABEL HERE

PATIENT INFORMATION SHEET

MRN_____ FULL NAME AS *WRITTEN* ON INSURANCE CARD_____

PREFERRED TO BE CALLED_____ DOB_____/_____/_____ SEX ☐ M ☐ F ☐ Non-Binary

ADDRESS 1_____

City/St/Zip_____

ADDRESS 2 _____

City/St/Zip_____

		May Text	Preferred #
Home Phone	_____	☐	☐
Work Phone	_____	☐	☐
Cell Phone	_____	☐	☐
Other Phone	_____	☐	☐

☐ **Yes, I agree to allow CCA to contact me via email.** Email Address _____
☐ **No, I do not want CCA to contact me via email.**
☐ **Yes, Please sign me up for the Patient Portal.** Email is required to sign up for the Patient Portal. The portal allows you to send a non-urgent message to your provider and for CCA to send a secure message to you. You will also receive signed office notes, test results, and lab results and may request other notes to be put on the portal. Future and past scheduled appointments are visible and you can request a rescheduling call back. ☐ **No, I do not wish to sign up for the patient portal at this time.**

Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Multiracial ☐ Other ☐ Pt Declined

Ethnicity ☐ Not Latino or Hispanic ☐ Latino or Hispanic ☐ Pt Declined ☐ Unknown

Preferred Language ☐ English ☐ Spanish ☐ Other_____ Do you need a translator? ☐ Yes ☐ No

Are you deaf or hearing impaired? ☐ No ☐ Yes ☐ I need a sign language interpreter.

Social Security Number_____ (Used for insurance verification and account duplication only)

Do you have an Advanced Directive, Living Will, DNR, Health Care Proxy and/or Power of Attorney?
☐ Yes ☐ No (If YES, please supply a copy to our office for your records.)

Primary Care Physician (PCP)_____ City_____ Phone_____

Preferred Pharmacies
Local:
Name_____ Address_____ Phone_____
Mail Order:
Name_____ Address_____ Phone_____

Prescription Insurance Plan

Name_____ ID#_____ Group#_____

RXBIN_____ Rx PCN_____ RxGRP_____

Insurance Information

Primary Plan_____ ID#_____ Group#_____

Secondary_____ ID#_____ Group#_____

Worker's Comp/No Fault Contact Name_____ Phone #_____

SIGNATURE_____ DATE _____

Guardian or Proxy Signature _____ DATE _____