

**GCCC PATIENT INFORMATION FORM**  
(PLEASE PRINT)

DATE \_\_\_\_\_ ALLERGIES \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_-\_\_\_\_-\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_-\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_-\_\_\_\_ ext. \_\_\_\_\_

CELL PHONE (\_\_\_\_) \_\_\_\_-\_\_\_\_ E-MAIL \_\_\_\_\_@\_\_\_\_\_

PLEASE CIRCLE:    MALE    FEMALE                      MARITAL STATUS:    S    M    W    D

**WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?**

NAME \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_-\_\_\_\_

RELATIONSHIP \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

**INSURANCE INFORMATION -- PLEASE ALSO PRESENT INSURANCE CARDS**

**PRIMARY INSURANCE** \_\_\_\_\_

POLICY ID \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SUBSCRIBER'S EMPLOYER \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_

POLICY ID \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SUBSCRIBER'S EMPLOYER \_\_\_\_\_

I hereby authorize Greater Cincinnati Cardiovascular Consultants, Inc. (GCCC) to submit claims to my health insurance company for all covered services rendered by GCCC, and direct the health insurance company to issue payments directly to GCCC. This authorization will remain in effect until revoked. I authorize the physician to furnish complete information to my health insurance company regarding services rendered, and I hereby assume responsibility for any charges not covered by my health insurance. **Patients are responsible for obtaining referrals for all office visits and/or diagnostic tests.**

**Signature of Subscriber or Patient\*\*** \_\_\_\_\_

I hereby acknowledge that I was given a copy of the Notice of Privacy Policy issued by GREATER CINCINNATI CARDIOVASCULAR CONSULTANTS, INC. on the date indicated below.

Signature\*\* \_\_\_\_\_ Date \_\_\_\_\_

\*\* If signed by other representative of the Patient, please print name and indicate type of relationship.