SIDNEY PEYKAR, M.D., F.A.C.C.

CLINICAL CARDIAC ELECTROPHYSIOLOGY

COMPLEX ARRHYTHMIA ABLATION
AND CARDIAC DEVICES

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LAST NAME: ______________________________ FIRST: ______________________________ MI: ______

ADDRESS: ____

CITY: ____________________________________ STATE: _____________ ZIP CODE: _________________

SECONDARY ADDRESS: ____

CITY: ____________________________________ STATE: _____________ ZIP CODE: _________________

DATE OF BIRTH: __________________________ HOME PHONE: ____________________________

EMPLOYED BY: __________________________________ WORK PHONE: _____________________________

SOCIAL SECURITY #:_____________________________________

MARITAL STATUS (CIRCLE ONE): M S W D

SEX (CIRCLE): MALE FEMALE

DO YOU USE EMAIL? Y / N EMAIL ADDRESS: ____

REFERRING DOCTOR: ____

PRIMARY PHYSICIAN: ____

PREFERRED PHARMACY: ____

ONLY FILL OUT SPOUSE INFORMATION IF **YOU** ARE ON **THEIR** POLICY

SPOUSE FULL NAME: ____________________________________ SPOUSE'S DOB: ___________________

SPOUSE'S SOCIAL SECURITY #: ___________________________ WORK PHONE: ____________________

EMERGENCY CONTACT: _________________________________ RELATIONSHIP: ___________________

PHONE: _______________________

PERSON RESPONSIBLE FOR PAYMENT: ____________________ RELATIONSHIP: ___________________

<u>PATIENT PAYMENT RESPONSIBILITY</u> I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL OFFICE AND HOSPITAL COPAYMENTS, DEDUCTIBLES, AND CO-INSURANCE PAYMENTS. FEES ARE DUE AT TIME OF SERVICE.

<u>AUTHORIZATION AND ASSIGNMENT</u> I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO SIDNEY PEYKAR, MD FOR PROFESSIONAL SERVICES RENDERED. I AUTHORIZE SIDNEY PEYKAR, M.D. TO RELEASE ANY INFORMATION NECESSARY TO REQUEST CLAIM REIMBURSEMENT FROM MY INSURANCE CARRIER(S).

SIGNATURE: ____ DATE: _________________