New Patient Information (please print clearly)
Page 1 of 2

Thank you for putting your trust in The Heart Center. We constantly monitor the quality of our services and request that you complete this form to assist us in our evaluation.

1. **How were you referred to The Heart Center? (please circle one)**

Referring Physician	Phonebook
Internet	Family/Friend
Newspaper	Insurance Company Provider List
Radio	TV
Other______________________________	

2. **Is this your first visit to The Heart Center? _____YES _____NO**

3. **How many days did you need to wait for your appointment, from the time you called? _____**

First Name:_______________________ Middle Initial:______Last Name:______________________

Street Address:__________________________City:_________________State:________Zip:______

Home Phone:________________ Work Phone:__________________ Cell Phone:____________

Date of Birth: ___________________ Social Security No.:___________________________

Sex: ____Female ____Male Marital Status:___Married ___Single___Divorced___Widow

Email: __________________________

Race: ____ White
____ Black/African American
____ Asian
____ American Indian/Alaskan Native
____ Native Hawaiian/Pacific Islander
____ Hispanic or Latino Ethnicity

Emergency Contact: _______________________ Phone No.: ________________________

Referring Physician: _______________________ Address: _____________________________

Primary Care Physician:______________________ Address: _____________________________

(Continued)

New Patient Information (please print clearly)

First Name:______________________ Middle Initial:______Last Name:_____________________

Date of Birth: ____________________ Social Security No.:____________________________

Insurance Information:

Employer Name: ____

Employer Address: ____

1. **Primary Insurance Company**:____

   Policy #:_____________________________ Group #:________________________

   Address:_______________________________ Insured Name:____________________

   Insured Date of Birth:__________ Relationship: ___Self ___Spouse ___Child

   Insured Social Security #:_______________________

2. **Secondary Insurance Company**:____

   Policy #:_____________________________ Group #:________________________

   Address:_______________________________ Insured Name:____________________

   Insured Date of Birth:__________ Relationship: ___Self ___Spouse ___Child

   Insured Social Security #:________________________

____ __________________

Patient Signature **Date**

The Heart Center, a division of Hudson Valley Cardiovascular Practice, P.C.