

PLEASE PRINT

CARDIOLOGY ASSOCIATES OF SAVANNAH, L.L.C.

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PATIENT INFORMATION

Have you ever been seen by any of our Doctors? _____ No _____ Yes _____ Year _____

Patient's Name: _____ Date of Birth: _____ Age _____

Address: _____ City: _____

State: _____ Zip: _____ Sex: _____ Home Phone: _____

Patient's Social Security #: _____ Work Phone: _____

Employed By: _____ Referred by Doctor: _____

Employers Address: _____

I am currently employed: _____ Full-time _____ Part-time _____ Retired

Name of Spouse or Guardian: _____ Their Phone: _____

Spouse's Social Security #: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Work Phone: _____

Person responsible for the bill, if other than patient: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Medicare No. _____ Effective Date: _____ Is this primary? _____

Medicaid No. _____ Effective Date: _____ Is this primary? _____

State in which Medicare and/or Medicaid were issued? _____

Primary Insurance CO Name: _____

Is this a PPO or HMO? _____ If so do you have a co-pay? _____ Amount? _____

Is a referral form or number required for your visit today? _____

Policy #: _____ Address: _____

Secondary Insurance CO. Name: _____

Policy #: _____ Address: _____

We request that our charges for office visits be paid at of each visit. Please read and sign below:

I understand that I am financially responsible for all charges whether or not paid by my insurance carriers. I hereby authorize said assignee to release all information necessary to secure payments. I authorize the named insurance carrier to pay directly to the Doctor named.

Patient's Signature: _____ Date: _____