CARDIOVASCULAR INSTITUTE OF SCOTTSDALE
PATIENT DEMOGRAPHIC INFORMATION SHEET
(Please Print)

SS#: _____ - ____ - _____ PATIENT'S NAME:_____
Last Name, First Name Middle Initial

PERMANENT ADDRESS: _____APT # _____

CITY:_____ STATE_____ ZIP _____

LOCAL ADDRESS: _____APT # _____

CITY:_____ STATE_____ ZIP _____

DATE OF BIRTH: _____/_____/_____ SEX: (M / F) MARITAL STATUS (S /M /W /D)
Month day year

Phone #:(_____)_____- _____ Work Phone #:(_____)_____- _____
Other Phone #:(_____)_____-_____ Email:_____

Please completely fill out the following:

Race: □ American Indian OR Alaska Native
□ Asian
□ Native Hawaiian OR Other Pacific Islander
□ Black OR African American
□ Hispanic
□ White
□ Other Pacific Islander_____
□ Other Race: _____
□ Undetermined/Refused to Report

Ethnicity: □Hispanic/ Latino □Not Hispanic/Latino
□ Undetermined/Refused to Report

Language: □ English □ Russian
□ Indian (Includes Hindi) □ Spanish
□ OTHER:_____

PRIMARY CARE PHYSICIAN: _____ PCP Phone:(_____)_____- _____
Last Name First Name

Emergency Contact: _____ Phone:(_____)_____-_____
Last Name First Name

Relation to Patient: _____ Patient Employer: _____

Primary Insurance

Ins. Co. Name: _____

Policy ID#_____ Group #_____

Relation to Patient: _____

Insured's Name: _____

Insured's Date of Birth:_____ M / F

Insured's SS# _____

Secondary Insurance

Ins. Co. Name: _____

Policy ID# _____Group#_____

Relation to Patient: _____

Insured's Name: _____

Insured's Date of Birth: _____M / F

Insured's SS# _____

I gave a copy of my Primary Insurance Card (Y)/(N) _ I gave a copy of my Secondary Insurance Card(Y)/(N)

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Who may receive information regarding your Protected Health Information? (Check all that apply)

Spouse_____ Name: _____Date of Birth: ____/____/_____

Children ____ Name: _____Date of Birth: ____/____/_____
Name: _____Date of Birth: ____/____/_____
Parent/Guardian____ Name: _____Date of Birth: ____/____/_____
Name: _____Date of Birth: ____/____/_____
Significant Other/Friend Name: _____Date of Birth: ____/____/_____

May we leave detailed messages regarding test results and appointments on your answering machine? ___(Y) ___(N)

Consent to Obtain Prescription History:
I give my consent to obtain any and all records pertaining to my prescription history: **INITIAL AND DATE**_____

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I acknowledge that Cardiovascular Institute of Scottsdale may forward my personal health information to any facilities where testing or procedures may be scheduled. I may revoke this at any time by giving written notification to this provider.

Date:_____ Signature_____
Circle One (PATIENT/ PARENT /GUARDIAN)