



Cardiovascular Disease and Invasive Cardiology

W. Michael Bailey, M.D., F.A.C.C.
Maria H. Bartlett, M.D., F.A.C.C.

Juan M. Esnard, M.D., F.A.C.C.
Thomas L. Terry, M.D., F.A.C.C.

Please Print:

Last Name: _____ M.I.: _____ Home Phone #: _____

First Name: _____ Work Phone #: _____

Street Address # 1: _____ DOB: _____

Street Address # 2: _____ SS#: _____

City: _____ State: _____ Zip Code: _____ Sex: _____

Referring Physician: _____

Employed: _____ Employer/School: _____

Primary Insurance Company: _____

Emergency Contact Person: _____ Phone#: _____

ID#	Insured's SS#	Group #	Phone #	DOB

Secondary Insurance Company: _____

Emergency Contact Person: _____ Phone#: _____

ID#	Insured's SS#	Group #	Phone #	DOB

Authorization to Release Information and Assignment of Benefits:

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in lieu of the original.

Date: _____ Signature: _____