Patient Demographics

Mishkel Heart & Vascular Center
1599 NW 9th Ave, Suite#203, Boca Raton, FL 33486

FIRST NAME LAST NAME MIDDLE NAME

LOCAL ADDRESS APT # CITY/STATE ZIP

OUT OF STATE ADDRESS APT # CITY/STATE ZIP

HOME PHONE # CELL # DATE OF BIRTH

EMPLOYED BY EMPLOYER'S ADDRESS

SOCIAL SECURITY # SPOUSE'S NAME PRIMARY CARE PHYSICIAN

NEXT OF KIN (NOT LIVING WITH PATIENT) RELATIONSHIP TO PATIENT

KIN HOME PHONE # KIN CELL PHONE #

E-MAIL ADD_____

PHARMACY_____

PAYMENT IS EXPECTED AT TIME SERVICE IS RENDERED
THANK YOU.

WELCOME TO THE PRACTICE. TO ENSURE CONTINUITY OF CARE AND PATIENT SATISFACTION, ANY DIAGNOSTIC TESTING PERFORMED IN THE OFFICE WILL REQUIRE A FOLLOW UP APPOINTMENT TO REVIEW RESULTS. ANY URGENT ISSUES WILL BE CALLED IMMEDIATELY; HOWEVER, ALL OTHER RESULTS WILL BE DISCUSSED IN DETAIL AT FOLLOW UP VISIT. THIS WILL ALLOW YOU AN APPROPRIATE TIME TO ASK QUESTIONS AND BETTER UNDERSTAND YOUR RESULTS.

EXPLANATION OF PRACTICE POLICY:
ALL MEDICARE CLAIMS ARE SUBMITTED ELECTRONICALLY DIRECTLY TO MEDICARE FOR YOUR CONVENIENCE. PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED. I, THE UNDERSIGNED, HAVE READ THE ABOVE AND UNDERSTAND THAT ALL MEDICAL CHARGES INCURRED BY ME FOR SERVICES RENDERED ARE MY FINANCIAL RESPONSIBILITIES.

SIGNED:_____ DATE:_____