INTERNAL MEDICINE & CARDIOLOGY
BRONX MEDICAL-CARDIAC, PLLC.

Gurkan Taviloglu, M.D., FACC, FACP, FCCP

PATIENT INFORMATION

Date: _______________ SS# ________________________

Last Name: ____________________________ First Name: _______________________ MI: _____

Address: _________________________________ City: _____________ State: ____ Zip: _________

DOB: ____________ Age: _____ M:☐ F:☐ Marital Status: Single Married Divorced Widowed

Home Phone: __________________ Cell Phone: ____________________ Best Time to Reach: ________

Email Address: *(Please Print Carefully)* ____

Occupation: ________________________________ Employer Name: ___________________________

Employer Address: ___________________________________ Business Phone: ____________________

How did you hear about us? ____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: ______________________________ Relationship: ______________________________

Home Phone: ______________________________ Cell Phone: ______________________________

Referring Doctor: ____________________________ Phone Number: _______________________

INSURANCE:

Person Responsible for Insurance: Last Name: __________________ First Name: _____________ MI ___

Relation to Patient: _________________ DOB: ____________ SS# ____________________

Address (if different from Patient): ____________________ City: _____________ State: ___ Zip: _________

Insurance Co: ________________________________ ID#: __________________ Group: _____________

Medicare # _________________________________ Medicaid # _______________________________

Reason for today's visit: ____

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INSURANCE ASSIGNMENT AND RELEASE

I authorize use of this form on all my insurance submissions and permit authorization of payment directly to Dr. Gurkan Taviloglu. I understand if my insurance coverage does not pay for the services done on my behalf, I will be responsible of the outstanding charges.

Also, I give release of any information that my insurance company request upon my medical records and authorize Dr. Taviloglu or his staff to act as my agent in collecting payment from my insurance company. This consent will end when my current treatment plan is completed or one year from the date signed below.

Name (Print): ________________________________ Soc. Sec # _______________________

Signature: ___________________________________ Witness: __________________________

Date: __________________________