

Jorge Bordenave MD, PA

Functional & Integrative Cardiology
Diplomate American Board of Internal Medicine
Forensic Medicine & Forensic Examiner
Clinical & Nuclear Cardiology

NEW PATIENT INFORMATION

PLEASE PRINT

DATE: _____

EMAIL: _____

Name: _____

Address: _____

City, State Zip: _____

Date of Birth: _____ Gender: _____

SS#: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Insurance Company 1: _____

Policy #: _____

Insurance Company 2: _____

Policy #: _____

Referred by (PCP): _____

PCP Phone Number: _____

All professional services rendered are charged to patient. Necessary forms will be completed and expedited insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment

I hereby authorize _____ to furnish information to insurance carrier concerning my illness and treatment and I hereby assign to the physician payments for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by insurance.

Date: _____ Signature: X _____