Cardiac Institute of the Palm Beaches, PA
Jeffrey S. Fenster, MD, FACC

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Phone: 561-296-5225 Fax: 561-296-5226

Date:_____ Referred by:_____

Pharmacy Name:_____Location:_____Phone:_____

Name:_____
(Last) (Middle Initial) (First)

Address:_____
(Local address please)
City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Social Security Number:_____

Second Address:_____

City:_____ State: _____ Zip:_____

Phone:_____

E-Mail Address:_____

Emergency Contact:_____
(Name) (Phone)
Do you have an Advanced Care Plan (living will, power of attorney, etc)?_____

If our office is not contracted with your insurance plan, you will be considered out of network. Claims will be submitted to your insurance company on your behalf. However, charges for all services rendered are ultimately the responsibility of the patient and will be collected at the time of service. Your signature below is consent for medical treatment, consent to bill your insurance, and consent to provide any information required to process the claims.

_____ _____
(Signature) **(Date)**