Dominion Cardiac Care, P.C.- Seyed Hashemi MD, FACC

Stafford Office:
125 Hospital Center Blvd
Suite 315
Stafford VA 22554
Phone: (540) 657-6304
Fax: (540) 657-6261

Woodbridge Office:
14904 Jefferson Davis Hwy
Suite 202
Woodbridge VA 22192
Phone: (703) 490-3700
Fax: (703) 490-3799

PATIENT INFORMATION SHEET

Title: Mrs., Ms. Mr., Dr., (please circle) other: _____

Name: _____ Date of Birth: ___/___/___ Sex: ___M___F
Married_____ Single_____ Divorced_____ Widowed_____

Street: _____City: _____

State: _____Zip: _____Social Security #:_____

Contact Information:

Home: _____Cell: _____Work: _____Ext: ___
Which phone number is the best one to reach you? (circle one) Home Cell Work

Email (to be used for our Patient Portal- Coming Soon!): _____

Primary Care Physician: _____City/Town: _____Phone#: _____

Pharmacy Name: _____Pharmacy Tel#: _____

Emergency Contact: _____Tel#: _____

Relationship to Patient:_____

REFFERED BY:

Physician: _____ Friend/Family: _____Website: _____

INSURANCE INFORMATION (Please present Insurance Card(s) to Front Desk)

Primary Insurance Company _____

Street: _____City: _____State: _____Zip: _____

Name of Subscriber_____ Date of Birth____/_____/____

Relationship of Patient to Subscriber (circle one) Self Spouse Dependent

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Secondary Insurance Company _____

Street: _____City: _____State: _____Zip: _____

Name of Subscriber_____ Date of Birth____/_____/____

Relationship of Patient to Subscriber (circle one) Self Spouse Dependent

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AUTHORIZATION OF TREATMENT

My signature below indicates my consent for treatment as prescribed by Dominion Cardiac Care, P.C.- Seyed Hashemi, MD, FACC

ASSIGNMENT OF BENEFITS

I, the undersigned, have insurance coverage with (name of insurance) _____, and do assign directly to Dr Seyed Hashemi all medical benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

I understand that any charges incurred are ultimately my responsibility. If this account becomes delinquent, any fees incurred in the attempt to collect the balance will be added onto my debt. I also understand that there will be a $35 fee for any returned checks or insufficient funds. I have read and agree to the above terms and conditions.

Signature of Patient _____ Date _____