



PATIENT REGISTRATION

Last Name _____ First Name _____ Middle _____

Social Security Number _____ Date of Birth _____ Sex (M/F) _____

Race: African American _____ Asian _____ Hispanic _____ White _____ Other _____

Street Address 1 _____ Street Address 2 _____

City, State, Zip _____

Home Phone () _____ Day Phone () _____

Cell Phone () _____ E-Mail Address _____

Primary Care Physician _____ Referring Physician _____

Marital Status _____ Student Status: Full Time ___ Part Time ___ Not Student ___

Spouse's Name: _____ Spouse's Date of Birth _____

Employer _____ Occupation _____

Other Emergency Contact _____ Relationship _____

(Not living with you)

Home Phone () _____ Work Phone () _____

How Were You Referred to Our Office?

<input type="checkbox"/> Physician Referral	Physician's Name _____
<input type="checkbox"/> Patient Referral	Patient's Name _____
<input type="checkbox"/> Phone Book	Phone Book Name _____
<input type="checkbox"/> Newspaper	Newspaper Name _____
<input type="checkbox"/> Promotional Event	Event Name _____
<input type="checkbox"/> Insurance Requirements	Insurance Name _____

Insurance Information

Please Present Insurance Cards to Receptionist

Primary Insurance _____ Policy # _____

Group # _____ Effective Date _____

Name of Insured _____ Relationship to Patient _____

Is coverage through Employer? _____ Insured Employer _____

Secondary Insurance _____ Policy # _____

Group # _____ Effective Date _____

Name of Insured _____ Relationship to Patient _____

Is coverage through Employer? _____ Insured's Employer _____

**IF THE PATIENT IS INSURED BY MEDICARE,
PLEASE CIRCLE THE CORRECT RESPONSE.**

1. Do you/your spouse work for a company that provides you with health insurance? YES NO
If retired, please indicate the date you retired _____
2. Is this illness or injury the result of an automobile accident or other injury? YES NO
3. Is this illness/injury the result of an accident or illness that occurred at work? YES NO
4. Has treatment for this accident/illness been authorized by the Veterans Administration? YES NO
5. Are you entitled to any benefits under the Federal Black Lung Program? YES NO

**IF THE PATIENT IS A MINOR,
PLEASE COMPLETE THE FOLLOWING.**

Father's Name _____	Mother's Name _____
Date of Birth _____	Date of Birth _____
Address _____	Address _____
_____	Address _____
Home/Work Phone _____	Home/Work Phone _____
Employer _____	Employer _____

PLEASE SIGN:

I have read and understand the Notice of Information Practices provided to me by CARDIOVASCULAR MEDICINE, PC. I hereby authorize CARDIOVASCULAR MEDICINE, PC to disclose all or any part of my personal health information for treatment, payment and health operations as outline in the Notice of Information Practices.

Patient Signature

Date

I hereby authorize payment of any medical benefits for services rendered by CARDIOVASCULAR MEDICINE, PC directly to CARDIOVASCULAR MEDICINE, PC that would have otherwise been payable to me. I understand that amounts deemed by my insurance carrier to be beyond the "usual, reasonable, and/or customary" charges for said services will be paid by me.

Patient Signature

Date