Cardiovascular Medicine, PLLC

Patient Registration Form

TODAY'S DATE:			
PATIENT'S LAST NAME:	FIRST:	MIDDLE:	
SOCIAL SECURITY NO.:	BIRTH DATE: - -		SEX: ☐ M ☐ F
HOME ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME PHONE NO.: ( )	WORK PHONE NO.: ( )	CELL PHONE NO.: ( )	
EMAIL:	EMPLOYER:		
EMERGENCY CONTACT:		EMERGENCY CONTACT RELATIONSHIP:	
EMERGENCY CONTACT PHONE NO.: ( )			
RACE: ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ White ☐ Black or African American ☐ Decline to Specify			
PRIMARY LANGUAGE SPOKEN:	Primary Care Physician		
ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify			
MARITAL STATUS: ☐ Single ☐ Widow ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner			
INSURANCE INFORMATION – Please Present Cards to Receptionist			
PATIENT COVERED BY INSURANCE: ☐ Yes ☐ No		☐ Cash Patient	
NAME OF PRIMARY INSURANCE:			
POLICY HOLDER'S NAME:	POLICY HOLDER'S SOCIAL SECURITY NO.:	POLICY HOLDER'S BIRTH DATE: / /	
PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Child ☐ Other			
SECONDARY INSURANCE INFORMATION			
NAME OF SECONDARY INSURANCE:			
POLICY HOLDER'S NAME:	POLICY HOLDER'S SOCIAL SECURITY NO.:	POLICY HOLDER'S BIRTH DATE: / /	
PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Child ☐ Other			

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MEDICARE POLICY HOLDERS		
1). Do you or your spouse work for a company that provides you with health insurance?	☐ Yes	☐ No
If retired, please indicate the date in which you retired _____		
2). Is the illness or injury the result of an automobile accident or other injury?	☐ Yes	☐ No
3). Is the illness or 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 Veteran's Administration?	☐ Yes	☐ No
5). Are you entitled to benefits under the Federal Black Lung Program?	☐ Yes	☐ No

MINOR INFORMATION			
FINANCIALLY RESPONSIBLE PARTY – Please Provide Insurance Cards to the Receptionist			
FULL NAME:	SOCIAL SECURITY NO.:	BIRTH DATE: / /	
HOME ADDRESS (IF DIFFERENT FROM ABOVE):	CITY:	STATE:	ZIP CODE:
HOME PHONE NO.: ( )	CELL PHONE NO.: ( )	RELATIONSHIP TO PATIENT:	
EMPLOYER:	EMPLOYER PHONE NO.:	EXT.:	
EMPLOYER ADDRESS:	CITY:	STATE:	ZIP CODE:

I hereby verify that this information is accurate.

Signature _____ Date _____