American Heart Center, P.C. Patient Registration Form

Welcome to our office! We look forward to providing you with outstanding care.

Name:_____ Social Security#:_____

Date of Birth:_____ Sex: Male or Female (Please circle one)

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Primary Phone #:_____**Home Cell or Work**
(Please circle one)

Secondary Phone #:_____**Home Cell or Work**

Email Address:_____ Primary Care Physician:_____

Patient's Employer Name & Address:_____

Marital Status: Single Married Widowed Divorced Separated (Please circle one)

Emergency Contact's Name:_____Phone #:_____

Whom may we thank for referring you to our practice?:_____

Insurance Information

Primary Insurance Co:_____ Effective Date:_____

ID#:_____ Group#:_____

Subscriber's Name:_____ Subscriber's DOB:_____

Subscriber's SS#:_____ Relationship to Subscriber:_____

Secondary Insurance Co:_____ Effective Date:_____

ID#:_____ Group#:_____

Subscriber Name:_____ Subscriber's DOB:_____

Subscriber's SS#:_____ Relationship to Subscriber:_____

Medicare Lifetime Signature on File: (Please sign below if you have Medicare)
I request that payment of authorized Medicare benefits be made on my behalf to American Heart Center , P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these service payable for related services.

_____ _____
Patient, Parent, or Guardian Signature (if child is under 18 years old) Date

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned, authorize payment of medical benefits to American Heart Center, P.C. for any services furnished to me. I understand that I am financially responsible for any amount not covered by my insurance company. I also authorize you to release to my insurance company any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits.

_____ _____
Patient, Parent, or Guardian Signature (if child is under 18 years old) Date

Patient Name :_____

Please answer by circling yes or no.

Do you have a Medigap policy?	Yes	No
Do you have Medicaid?	Yes	No
Are you currently employed?	Yes	No
Are you covered under an employer or union policy?	Yes	No
Do you have a spouse/family member covered by a separate insurance policy?	Yes	No
Do you have a secondary insurance policy?	Yes	No
Are you here for treatment for injuries sustained related to a motor vehicle accident?	Yes	No

If yes, please provide:

Insurance Co:_____

Billing Address:_____

Your Claim #:_____ Date of Accident:_____

Your Policy #:_____

Claim Adjuster:_____ Adjuster's #:_____

Are you here for treatment for injuries sustained from a work related injury?	Yes	No

If yes, please provide:

Employer's Name:_____

Employer's Address:_____

Employer's Phone #:_____ Supervisor:_____

Worker's Compensation Insurance Co:_____

Billing Address:_____

Your Claim #:_____ Date of Injury:_____

Claim Adjuster:_____ Adjuster's #:_____

_____ _____

Patient's Signature Date