



CARDIOLOGY CONSULTANTS, LTD.

PATIENT REGISTRATION FORM

LAST NAME: _____ FIRST NAME _____ MIDDLE INITIAL: _____

SOCIAL SECURITY#: _____ - _____ - _____ DATE OF BIRTH: ____/____/____ GENDER: M / F

MARITAL STATUS (CIRCLE ONE) MARRIED / SINGLE / DIVORCED HOME PHONE (____) _____ - _____

ADDRESS: _____
(STREET) (CITY/STATE/ZIP)

DEMOGRAPHICS

RACE:

- WHITE/CAUCASION BLACK/AFRICAN AMERICAN ASIAN
 AMERICAN INDIAN / ALASKAN PACIFIC ISLANDER MULTI / BI-RACIAL OTHER

ETHNICITY:

- HISPANIC NON-HISPANIC

PREFERRED METHOD OF CONTACT:

- HOME PHONE (____) _____ - _____ CELL PHONE (____) _____ - _____
 TEXT MESSAGE (____) _____ - _____ OTHER PHONE (____) _____ - _____
 E-MAIL (e-mail address): _____

EMPLOYER NAME: _____ EMPLOYER PHONE NUMBER: (____) _____ - _____

EMPLOYER ADDRESS: _____
(STREET) (CITY / STATE / ZIP)

REFERRING / PRIMARY CARE PHYSICIAN: _____ COPAY AMOUNT \$ _____

PERSON RESPONSIBLE FOR BILL OR PARENT (COMPLETE ONLY IF DIFFERENT FROM PATIENT)

GUARANTOR NAME: _____ SOCIAL SECURITY#: _____ - _____ - _____

RELATIONSHIP TO PATIENT: (PLEASE CHECK): self spouse parent DATE OF BIRTH: ____/____/____

ADDRESS: _____ PHONE NUMBER: (____) _____ - _____

EMPLOYER NAME: _____ EMPLOYER PHONE NUMBER: (____) _____ - _____

EMPLOYER ADDRESS: _____
(STREET) (CITY / STATE / ZIP)



CARDIOLOGY CONSULTANTS, LTD.

WHO TO CALL IN THE EVENT OF AN EMERGENCY:

NAME: _____ RELATIONSHIP: _____ PHONE NUMBER: (____) ____ - ____

PRIMARY INSURANCE INFORMATION

PLAN NAME: _____ I.D. NUMBER: _____

ADDRESS: _____ GROUP NUMBER: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

POLICY HOLDER'S SOCIAL SECURITY#: ____ - ____ - ____

POLICY HOLDER'S DATE OF BIRTH: ____/____/____ GENDER: M / F

SECONDARY INSURANCE INFORMATION

PLAN NAME: _____ I.D. NUMBER: _____

ADDRESS: _____ GROUP NUMBER: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

POLICY HOLDER'S SOCIAL SECURITY#: ____ - ____ - ____

POLICY HOLDER'S DATE OF BIRTH: ____/____/____ GENDER: M / F

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y ____ N ____

IF YES, PLEASE NOTIFY THE RECEPTIONIST

I hereby instruct and direct my insurance company (ies) to pay by check made out and mailed to:
CARDIOLOGY CONSULTANTS LTD.

-or-

If my current policy prohibits direct payment to doctor, I hereby will also instruct and direct my insurance company to make out the check to me and will forward payment by mail to Cardiology Consultants, Ltd. for the professional or medical expenses allowable, and otherwise payable to me under my insurance policy as payment toward the charges for the progression services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFIT UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of the assignment of benefits shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account and for any professional services rendered. I have read all of the information on both sides of this form and acknowledge consent of all of the above. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

PATIENT / GUARANTOR SIGNATURE _____ / ____ 2011

PATIENT / GUARANTOR SIGNATURE _____ / ____ 2012

PATIENT / GUARANTOR SIGNATURE _____ / ____ 2013

PATIENT / GUARANTOR SIGNATURE _____ / ____ 2014