Associates in Cardiovascular Care, P.A.
REGISTRATION FORM

Today's date:	**Primary Care Physician :**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former / maiden name):	Birth date:	Age:	Sex:	
☐ Yes	☐ No			/ /		☐ M	☐ F

Street address:	Social Security no.:	Home phone no.:
		( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

E-MAIL ADDRESS:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	/ /		( )
Is this person a patient here?	☐ Yes ☐ No		

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	☐ Yes	☐ No	

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Associates in Cardiovascular Care, P.A. or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*