

PATIENT REGISTRATION FORM

Please Print Clearly

PATIENT NAME _____ TODAY'S DATE _____

STREET ADDRESS _____ P.O. BOX _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____ DATE OF BIRTH _____

SS# _____ SPOUSE/SIGNIFICANT OTHERS FIRST NAME _____

HOME PHONE _____ GENDER _____ MARITAL STATUS _____

PATIENT EMPLOYER _____

EMPLOYER ADDRESS _____

MAY WE CONTACT YOU AT WORK? _____ IF YES, WORK PHONE _____

NAME OF NEAREST RELATIVE (NOT LIVING WITH YOU) _____

RELATIONSHIP _____ PHONE _____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____

REFERRING PHYSICIAN _____

ADDRESS _____

PRIMARY INSURANCE CARRIER NAME _____

SUBSCRIBER NAME _____

SECONDARY INSURANCE CARRIER NAME _____

SUBSCRIBER NAME _____

PLEASE PRESENT YOUR INSURANCE CARDS FOR COPYING



CONSENT FOR USE OR DISCLOSURE OF
HEALTH CARE INFORMATION

I, _____ give Atlantic Cardiology Associates the right to use and disclose my medical record for the following reasons:

Treatment – I authorize the release of copies of my medical record to other physicians, hospitals or entities who are participating in my care and treatment.

Payment – I authorize Atlantic Cardiology to submit all charges to my insurance carrier and I assign benefits of said services payable to Atlantic Cardiology Associates. I also authorized release of all medical information necessary to secure payment of insurance benefits. I recognize and accept personal responsibility for any balance or fee not covered by my insurance carrier.

Health Care Operations – I authorize the use of my medical record during the daily operations at Atlantic Cardiology.

Patient Signature

Date

I acknowledge receipt of Atlantic Cardiology Associates Notice of Privacy Practices.

Name: _____

Signature: _____ Date: _____

MEDICARE BENEFICIARIES – LIFETIME SIGNATURE

I request that payment of authorized Medicare benefits be made to either me or on my behalf to ATLANTIC CARDIOLOGY ASSOCIATES for any services furnished me by that office. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature

Date