Adult

Pediatric Cardiology Associates Patient Registration

Patient Information

Patient Name: _____ Home Phone #:(____)_____

Address: _____ City: _____ Zip:_____

Date of Birth:_____/_____/_____ Sex: ☐Female ☐Male SS#:_____

Pregnant: ☐Yes ☐No Due Date:_____ e-mail:_____

Guarantor/Responsible Party

Name _____ Cell Phone #: (____)_____

Address: _____ City: _____ Zip: _____

Date of Birth:_____/_____/_____ SS#:_____ e-mail:_____

Employer: _____ Wk Phone #: (____)_____

Employer Address: _____ City: _____ Zip:_____

Insurance Information

*Primary Insurance Company:_____ ID#:_____ Group #:_____

Insurance Co Phone #: (____)_____ Policy Holder: _____ Relationship to Patient: ☐Self ☐ Other

*Secondary Insurance: _____ ID#:_____ Group#:_____

Insurance Co Phone #: (____)_____ Policy Holder: _____ Relationship to Patient: ☐Self ☐ Other

Name of Referring / PCP: _____ Phone: (____)_____

Address:_____

Name of Perintologist:_____ Phone: (____)_____

Address:_____

I hereby assign to this Practice, my physician or other healthcare professionals involved in my care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available, to pay for all services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. I understand that I am responsible for all charges (hospital and/or physician) until the bills are paid in full and for the balance of charges not covered by insurance.

How well do you speak English? ____ Very Well ____ Well ____ Not Well ____ Not At All Pref Lang _____

Ethnicity: Hispanic or Not Hispanic Race: Asian Black White Other _____

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

YOU MUST BE PREPARED TO PAY YOUR COPAY AND DEDUCTIBLE AT THE TIME OF YOUR APPOINTMENT