**Patient Registration**

**Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MI**\_\_\_\_\_  **Sex: M / F**

**DOB:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_

So**cial Security #:** \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ **Marital Status**: **S/M/W/D**

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **CONTACT PHONE NUMBERS EMPLOYER**

**Home:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Company Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Retired:** Y/N Unemployed**:** Y/N

**Primary:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Communications:** **□ Home Phone □ Cell Phone □ Work □ E-mail**

**For Appt. Reminders how would you like to be notified: □ TEXT □ Voicemail**

**Preferred Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cross Streets:** \_\_\_\_\_\_\_\_\_\_\_**City:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information**

**Preferred Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail address:\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity:**  □ Hispanic or Latino **OR** □ Non- Hispanic or Latino

**Race:**  □ **White** □ **Black or African American** □ **American Indian or Alaska Native**

 □ **Native Hawaiian or Other Pacific Islander** □ **Asian** □ **Other Race**

**Referring Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specialty Clinic’s** – **We’re not your Primary Care Physician, you were Referred to our Office. Does your Insurance Require a Referral for you to be seen? (Y/N)** \_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE COVERAGE**

**Primary Insurance Plan: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Primary Insured Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured Relationship to patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Are you the policy holder or is your spouse/parent (Parent, Legal Guardian, Spouse)

**Insurance ID Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Group Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Insured Soc. Sec :**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Insured Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Secondary Insurance Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Insured Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured Relationship to patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Are you the policy holder or is your spouse/parent (Parent, Legal Guardian, Spouse)

**Insurance ID Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Group Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Insured Soc Sec #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Insured Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE AUTHORIZATION & ASSIGNMENT, & PAYMENT RESPONSIBILITY** - I HEREBY AUTHORIZE ADVANCED HEART AND VEIN CENTER TO FURNISH INFORMATION TO ANY AND ALL INSURANCE CARRIERS CONCERNING MY MEDICAL RECORDS AND TREATMENTS. I AUTHORIZE ADVANCED HEART AND VEIN CENTER TO APPEAL ANY UNPAID INSURANCE CLAIMS ON MY BEHALF. I HEREBY ASSIGN TO THE PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF. I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND ALL THE CHARGES INCURRED FROM THOSE SERVICES. ALTHOUGH I HAVE REQUESTED THE PRACTITIONER TO BILL MY INSURANCE COMPANY ON MY BEHALF, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE FOR ANY REASON. I WILL ALSO BE RESPONSIBLE FOR ANY CO-PAYS, CO-INSURANCE AMOUNTS, AND DEDUCTIBLES. ANY PAYMENTS MADE DIRECTLY TO THE PATIENT AND OWING TO THE PHYSICIANS WILL BE REMITTED IMMEDIATELY, PAYABLE TO ADVANCED HEART AND VEIN CENTER, INC. PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. I AM RESPONSIBLE FOR FURNISHING ALL THE INFORMATION REQUESTED ABOVE, AND ALSO RESPONSIBLE FOR FURNISHING ANY NECESSARY INSURANCE FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION OR OFFICE SURGICAL PROCEDURES. IF THERE IS A DEFAULT IN ANY ONE PAYMENT (NO PAYMENT WHEN DUE) THERE WILL BE AN ADDED 30% COLLECTION OR REASONABLE ATTORNEYS' FEE, PLUS ALL COSTS, IF MY ACCOUNT GOES TO A COLLECTION AGENCY OR COLLECTION ATTORNEY FOR COLLECTION OR LITIGATION.

**No Show Notice to Patients**: Please provide us with a minimum of 24 hours advance notice if you must cancel an appointment.

**Signature of Patient/Authorized Person:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_