PATIENT REGISTRATION FORM

Patient's Name_____ SS#_____

Martial Status: ◻ S ◻ M ◻ W ◻ Div ◻ Sep Sex: ◻ Male ◻ Female Birth date_____ Age_____

Language_____, Race_____, Ethnicity: ◻ Hispanic ◻ Non-Hispanic

Street Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Employer_____

Spouse Name_____ Birth date_____

Relative's Name_____ Phone_____

Has any other family member been treated in this office? ◻ Yes ◻ No Who?_____

Referring Physician's Name_____ Phone_____

INSURANCE INFORMATION

Primary Insurance_____ ID#_____ Group#_____

Name of Policy Holder_____ Effective Date_____

Claims Address_____

Secondary Insurance_____ ID#_____ Group#_____

Name of Policy Holder_____ Effective Date_____

Claims Address_____

ALL COPAYS AND DEDUCTIBLES ARE PAYABLE AT THE TIME OF SERVICE. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. HMO AUTHORIZATIONS ARE REQUIRED PRIOR TO YOUR APPOINTMENT.

INSURANCE AUTHORIZATION: I hereby authorize Atlanta Heart Group, P.C. to furnish information carrier or other health practitioners concerning my illness and treatment. I understand that I am responsible for my account, regardless of my insurance coverage.

Signature_____ Date_____