PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI: __________

Street Address: ______________________ City: ______________ ST: ______ ZIP: __________

Home Phone: ______________________ Cell Phone: ______________________ Work Phone: ______________________

Date of Birth: ______________________ Gender: ( ) M ( ) F SSN: ______________________ Preferred Language: ______________

Email Address: ______________________

Race:
( ) American Indian / Alaskan Native
( ) Asian
( ) Black / African American
( ) Native Hawaiian / Pacific Islander
( ) White
( ) Other
( ) More than one race
( ) Decline to Report / Unavailable

Ethnicity:
( ) Hispanic or Latino
( ) Not Hispanic or Latino
( ) Decline to Report / Not Available

Marital Status:
( ) Married ( ) Single
( ) Divorced ( ) Widow

How did you hear about us?
( ) Relative / Friend
( ) Internet
( ) Doctor
( ) Other

Employer: ______________________ Occupation: ______________________ Work Phone: ______________

Primary Care Physician Name: ______________________ Address: ______________________ Phone: ______________

Referring Physician Name: ______________________ Address: ______________________ Phone: ______________

SPOUSE INFORMATION

Last Name: ______________________ First Name: ______________________ MI: __________

Street Address: ______________________ City: ______________ ST: ______ ZIP: __________

Date of Birth: __________________ SSN: ______________________ Contact Phone: ______________________

INSURANCE INFORMATION

Primary Insurance Company: ______________________ ID: ______________________ Group #: __________________

Street Address: ______________________ City: ______________ ST: ______ ZIP: __________

Name of Insured (Policy Holder): ______________________ Policy Holder Phone: ______________________ Policy Holder Date of Birth: __________________

Policy Holder SSN: ______________________

Secondary Insurance Company: ______________________ ID: ______________________ Group #: __________________

Street Address: ______________________ City: ______________ ST: ______ ZIP: __________

Name of Insured (Policy Holder): ______________________ Policy Holder Phone: ______________________ Policy Holder Date of Birth: __________________

Policy Holder SSN: ______________________

EMERGENCY CONTACT

Last Name: ______________________ First Name: ______________________ Relation to Patient: ______________

Street Address: ______________________ City: ______________ ST: ______ ZIP: ______________

Home Phone: ______________________ Cell Phone: ______________________ Work Phone: ______________________

I hereby assign my insurance benefits to be paid to Peak Heart and Vascular. I understand that I am financially responsible for this bill regardless of insurance coverage. I also authorize the release of any information required in the processing of insurance claims. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required). I have been given a copy of the Patient Financial Responsibilities Form.

Signature: ______________________________ Date: ______________________