St David's Heart & Vascular

Patient Registration Form

(Please print or write legibly)

Last Name:_____ First:_____ MI:_____

Gender: ☐Male ☐Female Date of Birth:_____ Social Security:_____

Mailing Address:_____ Apt. #:_____

City:_____ State:_____ Zip:_____

Please check the preferred primary phone number:

☐Home Phone: (_____)-_____ ☐Work Phone: (_____)-_____

☐Mobile Phone: (_____)-_____ Email:_____

Preferred Language:_____ Marital Status:_____ Race/Ethnicity:_____

Emergency Contact Person:_____ Relationship:_____

Primary Number: (_____)-_____ Secondary Number: (_____)-_____

Primary Care Physician:_____ Referring Physician:_____

Employer's Name:_____ Occupation:_____

Employer's Mailing Address:_____ Suite #:_____

City:_____ State:_____ Zip:_____

Insurance

Insurance card(s) or proof of insurance must be presented at time of service.

Primary Insurance:_____ Policy #_____

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____/_____/_____

Secondary Insurance:_____ Policy #_____

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____/_____/_____

Tertiary Insurance:_____ Policy #_____

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____/_____/_____

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to St. David's Heart & Vascular, PLLC. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____ _____

Signature of Patient or Personal Representative **Date**

Financial acknowledgement for Private Pay Patients or Patients without Insurance

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____

Signature of Patient or Personal Representative **Date**