St David's Heart & Vascular

Patient Registration Form

(Please print or write legibly)

Last Name:______________________________First:______________________________MI:__________

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Choose not to disclose

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**