

**THE HEART CENTER OF THE ORANGES
REGISTRATION INFORMATION**

(PLEASE PRINT)

Date _____ Home Phone _____

Patient _____
Last Name First Name Initial

Responsible Party (if a minor) _____

Street Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birth date _____ Single Married Widowed Separated Divorced

Employed Full-Time Student Part-Time Student Patient's School Name _____

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

Spouse (or responsible Party) Name _____ Birth date _____

Business Name and Address _____

Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? No Yes If yes,

Name of Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any) _____

Contract # _____ Group # _____ Subscriber # _____

Are you covered under any of these programs? Medicare Medicaid CHAMPUS CHAMPVA

Worker Compensation FECA Black Lung I.D # for program you've checked

If Welfare, your number _____ Country of _____

Is your condition related to employment (current or previous)? No Yes

(OVER)

OFFICE NOTES

Beneficiary Signature _____

Date _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. *The Heart Center of the Oranges* for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

MEDICARE AUTHORIZATION

Signature of Insured/Guardian _____

Date _____

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. *The Heart Center of the Oranges* all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____

Name of Insurance Company _____

Whom may we thank for referring you? _____

How did you learn of our practice? _____

Reason for seeing _____

2. _____
(General Practitioner, Specialist, or other)

City/State _____

Reason for seeing _____

1. _____
(General Practitioner, Specialist, or other)

City/State _____

Please list other doctors you have seen in the past 5 years:

Phone _____

Relationship to patient _____

In case of emergency, who should be notified? _____

Other Accident? No Yes Please describe _____

Is your condition related to auto accident? No Yes In which state? _____