The Heart Center of the Oranges

Registration Information

(PLEASE PRJNT)

Patient: _____ SS#: _____
Last Name, First Name MI

Street Address: _____ Apt#: _____ City: _____

State: _____ Zip Code: _____ Home Phone#: _____ Cell Phone#: _____

DOB: _____ Female ☐ Male ☐ Other ☐ Marital Status _____

Race: _____ Ethnicity: _____Language Spoken: _____Email:_____

Pharmacy Name: _____ Telephone # :_____

Employer: _____ Occupation: _____ Telephone #: _____

Emergency Contact:

Name: _____ Phone #: _____ Relationship: _____

Primary Insurance Name: _____ ID #: _____ Group #: _____

Insured: _____ DOB: _____ Relationship: _____

Secondary Insurance Name: _____ ID #: _____ Group #: _____

Insured: _____ DOB: _____ Relationship: _____

Primary Care Physician: _____ Location: _____

Were you involved in a Motor Vehicle Accident: Yes ☐ No ☐ Were you injured at Work? Yes ☐ No ☐

Insurance Name: _____Claim #: _____ DOA #: _____

Adjustor: _____ Telephone#: _____Fax#: _____

Assignment and Release:

I, the undersigned, have medical insurance coverage with _____and assign directly to *The Heart Center of the Oranges* all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges related to treatment I receive by the providers of *The Heart Center of the Oranges* whether or not paid by my insurance. I hereby authorize *The Heart Center of the Oranges* to release all my information necessary to my Insurance company in order to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions whether manual or electronic.

Acknowledgement of Receipt of Notices of Privacy Practices

I, _____ have received the notice of privacy practices from The Heart Center of the Oranges.

_____ _____

Patient Signature Date