PREMIER CARDIOLOGY CONSULTANTS, PLLC

REGISTRATION FORM / PLEASE PRINT LEGIBLY

I. Patient Information

Patient Name _____ Sex____M___F____ Date of Birth _____/_____/_____
Last First

Martial Status _____
Social Security #_____-_____-_____ (S M W D)

Home Number _____ Cell Number _____ Work Number _____

Address_____ _____ _____ _____
Street City State Zip

Father' First Name _____ Mother's First Name _____ Are you employed? ____ Yes ___ No
If yes complete section! IV

Emergency Contact _____ Telephone Number _____ Relationship _____

II. Referral Information

Who referred you to our office? Name _____ Telephone Number_____
Last First

Address _____ _____ _____ _____
Street City State Zip

III. Primary Care Information (PCP)

Primary Physicians Name _____ Telephone Number _____
Last First

Address _____ _____ _____ _____
Street City State Zip

IV. Employer Information

Name of Employer _____ Work Number _____

Address _____ _____ _____ _____
Street City State Zip

V. Spouse Information

Spouse's Name _____ Sex __M __F Date of Birth _____/____/_____

Spouse's Social Security # _____-_____-_____ Spouse Employed by _____

Spouse's Employer Address _____ _____ _____ _____
Address City State Zip

Insurance Information (Please provide insurance cards for verification)

VI. PRIMARY

Insurance Coverage _____ Relationship to Subscriber _____
Name of Insurance Carrier Self, Spouse, Child, Student

Subscriber's Name _____ Subscriber's Date of Birth _____/_____/_____
Last First

Insurance ID Number _____ Group Number _____ Plan Number _____
Please provide number from Card

Claims Address _____ _____ _____ _____
Street City State Zip

Authorization for release of information by Premier Cardiology Consultants, PLLC

I hereby authorize and direct the above named clinical practice, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my medical care, all information a needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care treatment.

VII. _____ ____/_____/_____
Signature of Patient or Authorized Representative Date