Cardiology Partners, LLP

Patient Registration

Please print clearly. Thank you!

NAME: _____ SEX: M ☐ F ☐

HOME ADDRESS: _____CITY:_____STATE:_____ ZIP:_____

HOME: (____) _____ WORK: (____) _____ CELL: (____) _____

BIRTHDATE:_____ SOCIAL SECURITY #:_____ MARITAL STATUS: S ☐ M ☐ D ☐ W ☐

RACE: _____ ETHNICITY:_____ EMAIL ADDRESS:_____

EMPLOYER'S NAME & ADDRESS: _____

_____ PHONE: (____) _____

SPOUSES'S NAME: _____ SOCIAL SECURTIY: _____

SPOUSE'S EMPLOYER: _____ PHONE: _____

PERSON/PARTY RESPONSIBLE FOR ACCOUNT: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: (___) _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

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PRIMARY INSURANCE COMPANY & ADDRESS: _____

_____ PHONE: (___) _____

NAME OF POLICY HOLDER: _____ D.O.B: _____

POLICY ID: _____ GROUP #: _____

SECONDARY INSURANCE COMPANY & ADDRESS: _____

_____ PHONE: (___) _____

NAME OF POLICY HOLDER: _____ D.O.B._____

POLICY ID: _____ GROUP # _____

PATIENT'S AUTHORIZATION: I authorize the release of any medical information necessary to process this claim and authorize payment of medical benefits to: **JAMES A. RICHARDSON, M.D., SHOAIB H. SAYA, M.D., ALAN M. TAYLOR II, M.D**., **MICHAEL D. VENINCASA, M.D. and BRANDY GRAHAM, FNP-BC** regardless of my insurance benefits, if any. I understand I am financially responsible for the fee for services rendered.

SIGNATURE: _____ DATE: _____

Revised: October 13, 2014