

BIRMINGHAM HEART CLINIC, P.C.

PATIENT REGISTRATION

MR.
MS.
MRS.

LAST NAME

FIRST NAME

MIDDLE

SOCIAL SECURITY NUMBER

AGE

DATE OF BIRTH

STREET ADDRESS

CITY

STATE

ZIP CODE

HOME PHONE NUMBER

EMPLOYER'S NAME

EMPLOYER'S ADDRESS

BUSINESS PHONE NUMBER

SPOUSE'S NAME

SPOUSE'S WORK PHONE NUMBER

NAME AND PHONE NUMBER OF NEAREST RELATIVE (NOT LIVING WITH YOU)

REFERRED BY

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

LAST NAME

FIRST NAME

MIDDLE

SOCIAL SECURITY NUMBER

AGE

DATE OF BIRTH

STREET ADDRESS

CITY

STATE

ZIP CODE

HOME PHONE NUMBER

EMPLOYER'S NAME

EMPLOYER'S ADDRESS

BUSINESS PHONE NUMBER

INSURANCE INFORMATION (Please fill out if insurance cards are not present.)

INSURANCE COMPANY	POLICY OR CONTRACT #	GROUP NUMBER	INSURED NAME

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or with any public agency and its agents to determine benefits for services provided and/or benefits for related services.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered and/or received a copy of Birmingham Heart Clinic's "Notice of Privacy Policies".

ASSIGNMENT OF BENEFITS: I hereby authorize payment or benefits be made directly to Birmingham Heart Clinic, P.C. for services provided to me by Birmingham Heart Clinic, P.C. I understand that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event my account becomes delinquent (in excess of 90 days old), I agree to pay the cost of professional collection services (30%).

X

DATE