

# ARRHYTHMIA ASSOCIATES REGISTRATION

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: (    )		
City:		State:		Zip Code:		Cell phone:	
Alternate address:							
Occupation:		Employer:			Work phone no.: (    )		
Referred by Dr.							
Primary Care Physician							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: (    )	
Occupation:	Employer:	Employer address:			Employer phone no.: (    )		
<b>Primary</b> Insurance Co Name and Address:							
Subscriber's name:		Subscriber's S.S. no.:	Subscriber Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
<b>Secondary</b> Insurance Co Name and Address:							
Subscriber's name:		Subscriber's S.S. no.:	Subscriber Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: (    )
			Work phone no.: (    )

I HEREBY AUTHORIZE Arrhythmia Associates to apply for insurance benefits on my behalf for services rendered, and to release any information, including medical, to my insurance carrier. I FURTHER AUTHORIZE my insurance carrier to issue payment of medical benefits directly to Arrhythmia Associates. I understand that any portion of the charges which are not covered by my insurance plan(s) are due and payable to me. I CERTIFY that the information given above is true and accurate. I AUTHORIZE release of my demographic and financial information to any collection attorney or agency representing Arrhythmia Associates, should such action become necessary and agree to be responsible for any attorney fees and court costs incurred.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date