Patient Registration Form

Patient Information

Last Name: _____ First Name: _____ MI: _____

Street Address: _____Apt#:_____

City: _____State: _____ Zip code: _____

Home Phone # ( ) _____ Cell Phone # ( ) _____

Work # ( ) _____ Ext._____

Email Address: _____

Date of Birth: ____/____/____ SSN: _____-_____-_____ Gender: Male_____Female_____

Marital Status: Single_____ Married_____Widow_____Separated_____

Emergency Contact: _____Relationship_____

Home Phone# ( ) _____Cell Phone# ( ) _____

Primary Care Physician: _____Phone#:_____

Address: _____City: _____

State: _____Zip code: _____

Reason for visit: _____

Employer Information

Name of Employer: _____Phone # ( ) _____

Address: _____City_____

State: _____Zip code: _____

Occupation: _____ May we contact you at work? Yes____No_

Guarantor Information (Responsible Party for Bills)

Guarantor's Name: _____

Relationship to Patient: Self_____Spouse_____Child_____Other:_____

Home Phone# ( ) _____Cell Phone # ( ) _____Work# ( ) _____

Address: _____City:_____

State: _____Zipcode:_____

Employer: _____Address_____

City: _____State:_____Zipcode:_____

Guarantor's Date of Birth: ____/____/____ Guarantor's SSN: ____-____-____

Primary Insurance

Name of Primary Insurance: _____Phone # ( ) _____

Address:_____

City: _____State:_____Zipcode:_____

Policy# _____Group#_____Copay $_____

Effective Date: ____/____/____

Secondary Insurance

Name of Secondary Insurance: _____Phone # ( ) _____

Address:_____

City: _____State:_____Zipcode:_____

Policy# _____Group#_____

Effective Date: ____/____/____

1. I authorize the release of any medical information necessary to process my insurance claims(s) to 2020 MD Medical Billing.

2. I authorize and request payment of medical benefits directly to my Physician(s) at Keystone Cardiovascular Center

3. I agree that a photocopy of this form may be used in lieu of the original.

4. I agree to pay all charges not covered by my insurance carrier(s). These charges include but not limited to deductibles, co-payments, co-insurance and non-covered services.

Patient/Authorized Signature_____Date: _____/_____/_____