

CARDIOLOGY SPECIALISTS OF DAYTON, INC.

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information.

All information will be held strictly confidential.

PLEASE PRINT

Name_____Male____ Female____

Date of Birth_____ Social Security_____

Home Phone_____ Cell phone_____

Address_____ City_____ State_____ Zip_____

Race (Circle one) White Black Chinese Filipino Japanese Native American

Native Hawaiian Multiracial Oriental/Asian Pacific Islander Other_____ Undetermined

Employer_____

Work Phone_____ Extension_____

Spouse/Parent_____ Employer_____

Work Phone _____ Cell Phone_____

Family Physician_____ Office Phone_____

(First & Last Name, please)

Physician's Address_____

Emergency Contact _____ Phone_____

(Not living with you)

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For Office Use Only:	Account #	Physician
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INSURANCE INFORMATION

PLEASE FILL OUT COMPLETELY, SO THAT YOUR INSURANCE MAY BE FILED WITHOUT DELAY

You will be asked to provide a copy of all insurance cards at each visit

Primary Insurance_____ Policy #_____

Group #_____ Policy Holder Name_____

Policy Holder Birthday_____ Policy Holder Social Security_____

Secondary Insurance_____ Policy #_____

Group #_____ Policy Holder Name_____

Policy Holder Birthday_____ Policy Holder Social Security_____

_____ HIPAA Privacy Notice Received

_____ MEDICARE SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made on my behalf to Cardiology Specialists of Dayton, Inc. for any services furnished to me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents my information to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

_____ RELEASE OF INFORMATION: I authorize Cardiology Specialists of Dayton, Inc. to release or obtain any medial or other information necessary for my medical care or to process insurance claims.

_____ FINANCIAL RESPONSIBILITY: I understand I am financially responsible for the fees for services rendered. I authorize the processing of medical insurance either by electronic or manual method. My signature below authorizes payment of all medical benefits to Cardiology Specialists of Dayton, Inc. for any services furnished me. I recognize my financial obligation of any co-insurance or deductible and non-covered services. Co-payments are due on the day of service.

Patient signature

Date

_____ I REFUSE TO SIGN THIS FORM. I AM AWARE THAT I AM TOTALLY RESPONSIBLE FOR THE PAYMENT AT THE TIME OF SERVICE.

Patient signature

Date

Witness signature

Date