Cardiovascular
& Heart Rhythm Associates, PA

PATIENT REGISTRATION INFORMATION

Patient Name: _____
Last First MI

Phone Number: _____
Cell Home Work

Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Race: Alaskan Native African American American Indian
Asian Indian White Other Decline to Specify

Ethnicity: Hispanic Non Hispanic
Decline to Specify

Marital Status: ☐ Married ☐ Widowed ☐ Single

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed

PRIMARY CARE PHYSICIAN / REFERRED BY: _____

Email Address: _____ Would you like to sign up for Patient Portal?
☐ Yes ☐ No

Primary Insurance	Policy Number	Group Number
Secondary Insurance	**Policy Number**	**Group Number**

ASSIGNMENT OF BENEFITS

I hereby assign all insurance benefits to which I am entitled, including Medicare, Private Insurance, and any other health plans, to Dr. _____. I agree and understand that I am financially responsible for all charges incurred for services rendered whether or not paid by insurance. By signing this page, I agree that all the information provided is true and agreed upon by all parties on the date signed.

_____

Print Name Signature of Patient or Legal Representative Date