Arizona Heart and Arrhythmia Clinic

Arizona Heart Clinic
REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐			
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F	
Social Security no.:	Home phone no.:	Mobile phone no.:	Work phone no.: ( )			
Primary Address	City:	State:	ZIP Code:			
Secondary Address	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Referred to practice by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital			
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other		
Other family members seen here:						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ☐ Yes ☐ No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ☐ Yes ☐ No					
Name of primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ 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.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Arizona Heart and Arrhythmia Clinic LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*