HUMG-C: Advanced Cardiology Institute

Patient Registration Form (please print) **Date:** _____

Patient Information

Patient's Last Name _____ First Name _____

Address _____ Apt _____City _____ State _____ Zip_____

Home Phone ( )_____ Work Phone ( )_____ Ext _____

Cell Phone ( )_____ E-Mail address _____

Social Security #_____Date of Birth _____/_____/_____ Age _____ Sex: ___M ___F

Marital Status: ___Single ___Married ___Widow ___Separated ___Divorced Reason for visit: _____

Emergency Contact _____ Relationship _____ Phone ( )_____

Pharmacy Name _____City _____ Phone ( )_____

How did you hear about our practice? _____

Due to new government regulations, this is a requirement. However, you have the option to refuse. _____I refuse

Ethnicity _____ Race: ___ White ___African American ___Asian ___ Hispanic ___Other _____Language

Primary care physician: _____

Employer Information

Employer _____Employer Phone #_____

May we contact you at work _____yes _____no

Primary Insurance Information

Primary Insurance Name_____ Telephone ( )_____

Address _____City _____ State _____ Zip_____

Policy # _____Group# _____ Effective Date_____/_____/_____

Is referral needed? _____yes _____no Co-pay $_____

Name of Insured _____ Relationship to Patient _____self ____spouse ____child ____other

Insured's date of birth: _____/_____/_____ Insured SS# _____

Secondary Insurance Information

Secondary Insurance Name_____ Telephone ( )_____

Address _____City _____ State _____ Zip_____

Policy # _____Group# _____ Effective Date_____/_____/_____

Is referral needed? _____yes _____no Co-pay $_____

Name of Insured _____ Relationship to Patient _____self ____spouse ____child ____other

Insured's date of birth: _____/_____/_____ Insured SS# _____

Patient Privacy

In order to protect your privacy and in accordance with Federal law, we do not leave confidential medical information on answering machines or with anyone other than the patient or patient's legal guardian.

Please indicate your preferences below:

_____We may leave detailed messages on this answering machine #( )_____.

_____Do not leave detailed messages on any answering machine.

_____You may leave messages with the following individual(s)

Name(s)_____ #( )_____.

_____ #( )_____.

_____ #( )_____.

1. I authorize the release of any medical information necessary to process my insurance claim(s) to Millennium Practice Management Associates, Inc.
2. I authorize and request payment of medical benefits directly to my physician(s) at HUMG-CP
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 are not limited to deductibles, co-payments, co-insurance and non-covered services.

_____ Date _____/_____/_____

Patient/Authorized Signature