Cardiology Associates of Atlanta

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential. Also, please provide the receptionist a picture id and your insurance card

Patient's Name	Sex M F	Date of Birth Age	Marital Status Single **[ ]** Married **[ ]** Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone: Cell Phone:	Patient's Social Security #
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Date of birth	Responsible Party's Social Security #
Responsible Party Drivers License # State: Number		Occupation	How Long at current Employer?
Email Address:			
Name of employer Address		Business Phone	Occupation

Name of Spouse/Parent	Birth date	Social security #	Business phone

Reason for Visit:	**Referred by: (include address and phone)**	**How did you hear about us?**
Person to contact in case of emergency:	Relationship to patient	Phone

Medicare Yes **[ ]** No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date

Medicare Secondary insurance name Address	Policy #	Group #
Primary insurance company Address		Is insurance through your employer?

Subscriber Name	Subscriber birth date	Policy #	Group #
Secondary insurance name Address		Policy #	Group #

Medicare/Medicaid Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Cardiology Associates of Atlanta for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services

_____ _____

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Cardiology Associates of Atlanta for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for medical benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date