HEART& VASCULAR CLINIC

118 Sandhill Drive
Suite #104
Middletown, DE 19709
(302) 261-8200

620 Stanton Christiana Road
Suite #203
Newark, DE 19713
(302) 338-9444

REGISTRATION FORM

(Please Print)

Today's date:						
PATIENT INFORMATION						
Patient's last name: First: Middle Initial:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Social Security no.:	Date of Birth: / /	Age:	Sex: ❑ M ❑ F	Home phone no ( )	Cell phone no.: ( )	
Street address:			P.O. box:			
City:			State:		ZIP Code:	
Occupation:	Employer:				Employer phone no.: ( )	
Employer Street address:			City:		State:	ZIP Code:

PRIMARY CARE PHYSICIAN AND PHARMACY INFORMATION			
Primary Care Physician:	Physician Phone:		
Physician Street address:	City:	State:	ZIP Code:
Pharmacy:	Pharmacy Phone:		

EMERGENCY CONTACT INFORMATION			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

PRIVACY PRACTICE ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Birthdate: _____

Signature:_____ Date: _____

INSURANCE INFORMATION

(Please give your all of your medical insurance cards to the receptionist.)				
Name of primary insurance:				
ID no.:			Group no.: (Medicare does not have a group no.)	
Subscriber's name:		Subscriber's S.S. no.:		Subscriber's Date of Birth: / /
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance (if applicable):				
ID no.:			Group no.: (Medicare does not have a group no.)	
Subscriber's name:		Subscriber's S.S. no.:		Subscriber's Date of Birth: / /
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of tertiary insurance (if applicable):				
ID no.:			Group no.: (Medicare does not have a group no.)	
Subscriber's name:		Subscriber's S.S. no.:		Subscriber's Date of Birth: / /
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

AUTHORIZATIONS AND ACKNOWLEDGEMENTS:

- The above information is true to the best of my knowledge.
- I hereby authorize payment directly to the Heart and Vascular Clinic, P.A. for all benefits payable to me under the terms of insurance policy for treatment of services provided to my dependents or me.
- I authorize the release of any medical information necessary to process such insurance claims.
- I understand that I am financially responsible for any balances or charges not covered by my insurance(s).
- I herby authorize release of any medical information from hospitals, labs, or other physician's office to aid in my care.

Patient/Guardian signature	*Date*

EMAIL ADDRESS		