REGISTRATION INFORMATION

DATE _____

REFERRING PHYSICIAN _____ HOME PHONE _____
PRIMARY CARE PHYSICIAN _____

PATIENT _____ SOCIAL SECURITY # _____
Last Name First Name Middle

RESPONSIBLE PARTY (IF A MINOR) _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SEX ☐ M ☐ F AGE _____ BIRTHDATE _____ MARITAL STATUS _____

PATIENT'S EMPLOYER _____ WORK PHONE _____

WORK ADDRESS _____ CITY, STATE _____

PRIMARY INSURANCE _____ POLICY # _____ GROUP # _____
CLAIMS ADDRESS _____ CITY, STATE _____
INSURANCE CO PHONE # _____
SUBSCRIBER'S NAME _____ BIRTHDATE _____ SOCIAL _____
SUBSCRIBER'S EMPLOYER _____ ADDRESS _____
CITY, STATE _____ WORK PHONE _____
RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____ POLICY # _____ GROUP # _____
CLAIMS ADDRESS _____ CITY, STATE _____
PHONE # _____
SUBSCRIBER'S NAME _____ BIRTHDATE _____ SOCIAL _____
EMPLOYER _____ ADDRESS _____
CITY, STATE _____ RELATIONSHIP TO PATIENT _____

Please identify the Laboratory your Insurance Company requires you to use.

QUEST _____ LABCORP _____ CDS _____ HOSPITAL _____ OTHER _____

MEDICARE ASSIGNMENT OF BENEFITS: I request that payment of authorized Medicare benefits be made either to me or on my behalf to SHORE HEART GROUP, PA for any services furnished me by SHORE HEART GROUP, PA. I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE _____ DATE _____

ASSIGNMENT OF BENEFITS: I hereby authorize and instruct any and insurance companies involved with my healthcare coverage to make payment directly to SHORE HEART GROUP, PA. This if for the Professional Medical Expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This payment shall not exceed my indebtedness to the above practice, and I have agreed to pay in current fashion any balance if said professional service charges are over and above this insurance portion of payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to my insurance company, or adjuster involved in the case unless I have made alternative arrangements with respect to this data.

PATIENT'S SIGNATURE _____ DATE _____