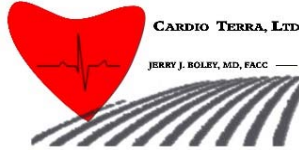


PATIENT REGISTRATION FORM

CARDIO TERRA, LTD
4112 MONROE ROAD
CELINA, OH 45822-9250
567-890-9000 PHONE#
567-890-9009 FAX#
WWW.CARDIOTERRA.COM



OFFICE USE ONLY
PS Acct# _____

PATIENT INFORMATION

NAME (FIRST) _____ (MI) _____ (LAST) _____
DATE OF BIRTH _____ AGE _____ SEX M ___ F ___ MARITAL STATUS S/M/W/D
ADDRESS _____ CITY, STATE, ZIP _____
SS# _____ HOME PHONE _____ WORK# _____
CELL# _____ EMAIL _____ EMPLOYER _____
ADDRESS _____ CITY, STATE, ZIP _____
REFERRING PHYSICIAN _____ PHONE _____
PRIMARY CARE PHYSICIAN (if different from above) _____
PREFERRED PHARMACY _____

RESPONSIBLE PARTY OR SPOUSE INFORMATION

FULL NAME _____ DOB _____ RELATIONSHIP TO PT: Self/Spouse/Depend.
ADDRESS _____
CITY, STATE, ZIP _____
HOME PHONE _____ WORK PHONE _____
CELL PHONE _____ SS# _____
EMPLOYER _____ ADDRESS _____
CITY, STATE, ZIP _____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME _____ PHONE _____
INSURANCE ADDRESS _____
CITY, STATE, ZIP _____
POLICY/I.D.# _____ GROUP# _____
INSURED'S NAME _____ DOB _____ RELATIONSHIP TO PT: Self/Spouse/Depend.
INSURED'S EMPLOYER _____ PHONE# _____
EMPLOYER'S ADDRESS _____
INSURED'S SS# _____ DATE OF BIRTH _____ SEX M ___ F ___

SECONDARY INSURANCE INFORMATION

INSURANCE NAME _____ PHONE _____
INSURANCE ADDRESS _____
CITY, STATE, ZIP _____
POLICY/I.D.# _____ GROUP# _____
INSURED'S NAME _____ DOB _____ RELATIONSHIP TO PT: Self/Spouse/Depend.
INSURED'S EMPLOYER _____ PHONE# _____
EMPLOYER'S ADDRESS _____
INSURED'S SS# _____ DATE OF BIRTH _____ SEX M ___ F ___

I hereby assign, transfer, and set over to CARDIO TERRA, LTD all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

PATIENT'S SIGNATURE: _____ DATE: _____