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:_____