

# Heart and Vascular Diagnostic Clinic, LLC REGISTRATION FORM

(Please Print)

Today's Date:	and Time:	Primary Care Physician:
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## PATIENT INFORMATION

Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.: - - -	Home phone no.: ( ) -		
P.O. Box:	City:		State:	ZIP Code:		
Occupation:		Employer:		Employer phone no.: ( ) -		
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.		
Contact Information of Referring Physician:	Phone: ( ) -	Fax: ( ) -	Cell: ( ) -	Other: ( ) -		
Is a referral necessary for this procedure?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is pre-authorization number necessary?				Authorization Number:		(Obtain from referring physician)

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( ) -		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( ) -		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance <input type="checkbox"/> Medicare <input type="checkbox"/> BlueCross/Shield <input type="checkbox"/> United Health <input type="checkbox"/> Aetna <input type="checkbox"/> TennCare					
<input type="checkbox"/> Other :	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> Other		
Subscriber's name:	Subscriber's S.S. no.: - -	Birth date:	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					

## IN CASE OF EMERGENCY

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