Broward Heart Specialists

PATIENT REGISTRATION

Todays Date: _____

Last name: _____ **First Name:** _____ **MI:** _____

Address: _____ **Apt#** _____

City: _____ **State:** _____ **Zip code:** _____

Birth Date: _____ **SS#** _____

Home Phone # _____ **Cell Phone#** _____

Work Phone # _____ **Email Address:** _____

IN CASE OF EMERGENCY PLEASE NOTIFY

Nearest Relative (not living with you)

Name: _____

Phone # _____

Friend (not living with you)

Name: _____

Phone# _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy# _____

Group# _____

Insured _____

if not self, must complete question below

Secondary Insurance: _____

Policy# _____

Group# _____

Insured _____

Name of Policy holder **D/O/B** **SS#** **RELANTIONSHIP**

REFERRAL INFORMATION

Referred by: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorized the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorized NBHD/Broward Heart Specialists to apply for benefits on my behalf for covered services rendered by his/her, or by his/her order. I request that payment from my insurance company be made directly to NBHD/Broward Heart Speciallists. If I am enrolled in an HMO or PPO insurance plan and my membership has lapsed or the service for my visit are not covered benefit, I understand that I will be financially responsible for the charges incurred.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature _____ Date: _____