Coastal Cardiovascular Care Patient Registration Form

Cardiologist:_____, M.D., F.A.C.C. **Primary Care Physician:** _____				
PATIENT INFORMATION	Acct#:	Gender:☐F ☐M	DOB: _ _ /_ _/ _ _	SSN:
	First Name:		Middle Initial:	Last Name:
	Previous Name(s):			Nickname (Goes By):
	Address:			City, State & Zip:
	Mailing Address: ☐ Same as above			City, State & Zip:
	Are you in a Skilled Nursing Facility or Hospice Program? ☐Y☐N			If yes, which?
	Do you have an Advanced Directive? ☐ Yes (if so, please provide a copy for our records) ☐ No			
	Home#:	Work#:		Cell#:
	Preferred Method of Contact: ☐ Text ☐ Email / Portal ☐ Letter ☐ Call			
	Email Address:			Primary Language:
	Please check the box(es) that describe your race: ☐American Indian or Alaska Native ☐Asian ☐Black ☐White ☐Decline to Specify ☐Other:			
	Please check the box(es) that describe your ethnicity: ☐ Latino ☐ Non-Latino ☐ Decline to Specify			
	☐ Employer:		☐ Retired ☐ Not Employed	Marital Status:
	Employer Address:			Employer Phone #:
INFORMATION	**Please be aware our receptionists will ask to review current identification and insurance cards.**			
	Primary Insurance:			Phone:
	Subscriber ID / Group:			Subscriber Name: ☐ Self
	Subscriber's DOB: _ _ /_ _/ _ _	Subscriber's Gender:☐F☐M		Relation to Patient:
	☐ Secondary Insurance:		☐No Secondary	Phone:
	Subscriber ID / Group:			Subscriber Name: ☐ Self
	Subscriber's DOB: _ _ /_ _/ _ _	Subscriber's Gender:☐F☐M		Relation to Patient:
CONTACTS	Emergency Contact's Name:			
	Date of Birth: _ _ / _ _ / _ _	Phone:		Relation to Patient:
	Address:			
	Alternate Emergency Contact's Name:			
	Date of Birth: _ _ / _ _ / _ _	Phone:		Relation to Patient:
	Address:			

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Coastal Cardiovascular Care physicians and physician assistants are licensed to practice in the state of California. I hereby authorize medical treatment by the staff and physicians of Coastal Cardiovascular Care, A Medical Corporation. I hereby authorize Coastal Cardiovascular Care, A Medical Corporation to exchange any medical records concerning my care with any physician, hospital or other health care professional who has provided or will provide me with medical care. Additionally, I authorize the practice to release any medical records concerning my care to my medical insurance company. I am aware that medical records may include sensitive and privileged information. I am aware that without this authorization Coastal Cardiovascular Care will not bill my insurance company and I am responsible for full payment at the time of service.

I am aware of the privacy standards of Coastal Cardiovascular Care and my rights and responsibilities as a patient under the Healthcare Portability Act of 1996 (HIPAA) and other governmental regulations. Should I request additional information, it will be provided by Coastal Cardiovascular Care staff. Otherwise, all exchanges of information including prescription history, medical history, and conversations about my condition will be in accordance with stipulated policies and procedures. I have authorized the practice to release any and all information concerning my medical care to the individuals named as emergency contact and alternate emergency contact. This permission may be revoked at any time.

I realize that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier. I hereby assign insurance benefits to Coastal Cardiovascular for all services rendered by Coastal Cardiovascular Care. I am liable for all charges for services rendered. This authorization shall continue and be in full force and effect until revoked by me in writing.

♦Signature:_____ Date: _____

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Reviewed By (Coastal Cardiovascular Care Employee):_____ Date: _____