



# SHORE CARDIOLOGY CONSULTANTS

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## PATIENT REGISTRATION FORM

BASIC INFORMATION			
LAST NAME:	FIRST NAME:	DATE:	
ADDRESS:			
CITY:	STATE:	ZIP:	
PHONE #:	WORK #:	CELL #:	
DOB:	AGE:	SEX:	SS#
MARITAL STATUS: Circle one (SINGLE, MARRIED, DIVORCED, WIDOWED) SPOUSE NAME:			
OCCUPATION:		EMPLOYER:	
*WOULD YOU LIKE TO OBTAIN WEB ACCESS TO YOUR MEDICAL RECORDS: Y/N			
*PLEASE PROVIDE EMAIL FOR THE ABOVE:			
RACE (OPTIONAL): Circle one (WHITE, BLACK/AFRICAN AMERICAN, HISPANIC, AMERICAN-INDIAN/ ALASKA NATIVE, ASIAN, OTHER: _____)			
LANGUAGE (OPTIONAL): Circle one (ENGLISH, SPANISH, INDIAN, OTHER: _____)			
ETHNICITY (OPTIONAL): Circle one (HISPANIC/LATINO, NOT HISPANIC/LATINO)			

OTHER	
EMERGENCY CONTACT:	_____
PHONE #:	RELATION: _____
PRIMARY CARE PHYSICIAN (NAME/PHONE#/ADDRESS): _____	
PHARMACY (NAME/PHONE#/ADDRESS): _____	
INSURANCE INFORMATION: (Please provide office with your insurance cards)	
PRIMARY INS:	SECONDARY INS:
PRIMARY INS ID#:	SECONDARY INS ID#:
GROUP#:	GROUP#:
NAME OF INSURED:	DOB:
RELATION TO PATIENT:	DOB:

**\*ASSIGNMENT OF INSURANCE BENEFITS\***

I HEREBY AUTHORIZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS TO DRS. MOOSVI/COHEN/DEVITA FOR SERVICES RENDERED BY THEM, OR THE PERSON UNDER THEIR SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.

**\*AUTHORIZATION TO RELEASE INFORMATION\***

I HEREBY AUTHORIZE DRS. MOOSVI/COHEN/DEVITA TO RELEASE ANY MEDICAL RECORDS OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER CARE OR IN PROCESSING APPLICATIONS FOR MEDICAL BENEFITS.

**\*MEDICARE/MEDICAID\***

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT. I AUTHORIZE RELEASE OF ALL RECORDS ON REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO SHORE CARDIOLOGY CONSULTANTS, LLC.

PATIENT NAME (Please Print): \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE OF PATIENT/PARENT/GUARDIAN/P.O.A.: \_\_\_\_\_