

C.A.I
A Cardiovascular & Arrhythmia Institute

Patient Registration Form

Patient: _____
SS #: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone 1: () _____ Cell Home Work
Phone 2: () _____ Cell Home Work
Employer: _____

- **Email address** to be able to access our online Patient Portal: _____
- **If active in Portal, would you like to receive billing statements through email?** Yes No
- **Preferred Method of Contact** (please note we will make phone calls for most communication but may use this method for other communication needs): Letter Phone Email
- **Marital Status (please circle):** Single Married Widowed Divorced Separated
- **Race (please circle):** White Black or African American American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Undetermined (includes any race not listed)
- **Ethnicity (please circle):** Latino or Hispanic Not Hispanic or Latino Other
- **Gender (please circle):** Male Female
- **Language:** _____

Referred By : _____
Primary Care Physician: _____ Phone #: () _____
Emergency Contact: _____
Emergency Phone #: () _____

Insured Party Information (If other than yourself)

Name of Insured: _____ Phone: _____
Address of Insured: _____ City/State/Zip: _____
Employer of insured: _____
Date of Birth: _____ SS#: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group: _____
Address: _____ City/State/Zip: _____
Subscriber Name: _____ Relationship to Patient: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Address: _____ City/State/Zip: _____

Authorization & Assignment

I hereby authorize Cardiovascular and Arrhythmia Institute, LLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits. I hereby authorize direct payment of medical benefits to Cardiac Arrhythmia Institute, LLC, for services rendered. I understand that I am financially responsible for any balances not covered by my insurance. If this account is not paid promptly, and office deems it necessary to utilize a collection service, I agree to all reasonable collection fees and/or legal fees, plus the present balance of the delinquent account.

PATIENT SIGNATURE: _____ **DATE:** _____

RESPONSIBLE PARTY (if other than patient): _____ DATE: _____