C.A.I
A Cardiovascular & Arrhythmia Institute

Patient Registration Form

Patient: _____
SS #: _____ **Date of Birth:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone 1: ( )_____ **Phone 2: ( )**_____
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 __ Fax__
- **Marital Status**: Single____ Married ____ Widowed ____ Divorced____
- **Race:** White____ Black or African American ____ American Indian or Alaska Native____ Asian ____ Native Hawaiian or Other Pacific Islander ____ Undetermined (includes any race not listed or if you decline to answer)____
- **Ethnicity:** Latino or Hispanic____ Not Hispanic or Latino____ Other or Undetermined (includes any race not listed or if you decline to answer)____
- **Gender:** 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:_____

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