Please complete this form in its entirety leaving no blanks. If something does not apply to you or you are unsure, please write "N/A" (not applicable), "UNK" (unknown), or draw a line in that area. Thank you.

SeaCoast CARDIOLOGY CONSULTANTS, PLLC

Patient Registration Form

Welcome to our office. Please fill out all information completely. **PLEASE PRINT.**
All information will be kept strictly confidential.

How did you hear about our practice? Newspaper [ ] Phone Book [ ] Dr. Referred [ ] Website [ ] Tricare [ ] Other: _____

Patient's Name

Sex Male [ ] Female [ ]

D.O.B. ___/___/_____ **Age:** _____

Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]

Home Address **City** **State** **Zip**

Patient's SSN

Home #_____

Cell # _____

Work # _____

Can messages be left on your answering machine/voicemail?
Home: Yes [ ] No [ ] Cell: Yes [ ] No [ ] Work: Yes [ ] No [ ]

E-mail: _____

DISCLAIMER: I am giving consent for my e-mail to be used for informational newsletters by SeaCoast Cardiology Consultants, PLLC. I understand that my e-mail will not be given out for any other purposes without my consent.

X_____

Person financially responsible for this account

Self [ ] Spouse [ ] Other [ ] **D.O.B.**_____ **Home #** **Business #**

SSN _____

Responsible party's employer:

Patient's employer **Title**

Address **Business #** **Extension**

Name of Spouse

D.O.B.

Emergency Contact Name: _____ **City, State:** _____

Home #_____

Other #_____

Reason for Visit

Primary Care Physician: ***(include address & phone #)***

Primary Insurance Company **Address**

Insurance through your employer? Yes [ ] No [ ]

Spouse's employer? Yes [ ] No [ ]

Policy Holder's Name **D.O.B.** **Policy #** **Group #**

Secondary Insurance Company **Address** **Policy #** **Group #**

Policy Holder Name: **D.O.B.**

Medicare/Medicaid Lifetime Signature on file:

I request that payment of authorized Medicare or Medicaid benefits be made on my behalf to SeaCoast Cardiology Consultants, PLLC for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Center of Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services. I understand that I am financially responsible for any amount not covered by my contract.

_____ _____

Patient's / Guardian / Legal Representative's Signature **Date**

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to SeaCoast Cardiology Consultants, PLLC for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract, including co-payments. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient's / Guardian / Legal Representative's Signature **Date**

Garrett Rogers, MD, FACC
(910) 353-3000
29 Office Park Drive
Jacksonville, NC 28546