PATIENT REGISTRATION

DATE _____

PATIENT INFORMATION

LAST NAME				FIRST NAME		M. I.	ALIAS OR MAIDEN NAME
DATE OF BIRTH	SEX	MARITAL STATUS	RACE	SOCIAL SECURITY NUMBER		EMPLOYER NAME	
STREET ADDRESS					CITY	STATE	ZIP
HOME PHONE		WORK PHONE □ PATIENT □ OTHER (NAME)_____			CELL PHONE □ PATIENT □ OTHER (NAME) _____		
REFERRING PHYSICIAN				EMERGENCY CONTACT NAME & RELATIONSHIP		EMERGENCY CONTACT PHONE	
EMAIL ADDRESS				WRITTEN LANGUAGE		SPOKEN LANGUAGE	

RESPONSIBLE PARTY INFORMATION

LAST NAME			FIRST NAME		MI	ALLIAS OR MAIDEN NAME
DATE OF BIRTH	SEX	MARITAL STATUS	SOCIAL SECURITY NUMBER		RELATIONSHIP TO PATIENT	
STREET ADDRESS (if different from above)				CITY	STATE	ZIP
HOME PHONE		WORK PHONE □ PATIENT □ OTHER (NAME)_____		CELL PHONE □ PATIENT □ OTHER (NAME) _____		
EMAIL ADDRESS			EMPLOYER NAME		OCCUPATION	

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME	SUBSCRIBER NUMBER	GROUP NUMBER	COPAY
SUBSCRIBER'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO PATIENT
SUBSCRIBER's EMPLOYER NAME	SUBSCRIBER's HOME PHONE	SUBSCRIBER's WORK PHONE	

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME	SUBSCRIBER NUMBER	GROUP NUMBER	COPAY
SUBSCRIBER'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO PATIENT
SUBSCRIBER's EMPLOYER NAME	SUBSCRIBER'S HOME PHONE	SUBSCRIBER's WORK PHONE	

CONSENT TO CARE:

I consent to the plan of care proposed by Dr. John R. Dylewski. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. _____ INITIAL

NOTIFICATION OF RELEASE FOR PAYMENT

I understand that Arrhythmia Management Institute of South Florida will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions. _____ INITIAL

FINANCIAL AGREEMENT

I understand co-payments are due at the time of service. I assign payment from my insurance directly to Arrhythmia Management Institute of South Florida. I understand I am financially responsible to Arrhythmia Management Institute of South Florida for the charges not paid by insurqance and that those charges are due within 30 days of invoice. I understand that the bill from my provider is separate and distinct from hospital charges. _____ INITIAL

RECEIPT OF NOTICE OF HEALTH PRACTICES

I have received a coy of the Notice of Health Information Practices which provides information about how my health information may be used/disclosed. _____ INITIAL

I have read the above and understand its contents:

PATIENT's SIGNATURE _____ PARENT OR GUARDIAN _____ DATE _____