Brookhaven Heart

New Patient Registration

Clear Form

(Please complete, print, sign and bring at your visit)

Individual Information

Name (*First, Middle, Last*)			Birth Date *(MM/DD/YYYY)*
Social Security Number	Marital Status: ☐Single ☐Married ☐Other		Sex; ☐M ☐F
Mailing Address of Patient -Street		City	
State	Zip code	Home Phone	Cell Phone

Race: ☐Caucasian ☐African American ☐Hispanic ☐Asian ☐Other (specify) ☐Refuse to report

Preferred language: ☐English ☐Spanish ☐Other (specify)

Email: (optional)	Would you like to receive our e-mail news letter ☐ Yes ☐ No

Referral and Contact/s Information

Primary care Physician	Referring Physician	
Previous Cardiologist	Address	Phone
Pharmacy	Address	Phone
Next of Kin and/or Health care Proxy	Relationship	Phone

Would you choose your next of kin or health care proxy to act on your behalf?
☒No ☐Yes ☐ Other (specify)

How did you find us: ☒ Friend ☒Relative ☒Doctor ☒ Internet ☒Advertisement
☐ Insurance book ☐ Hospital visit ☒ Other(specify)

May we leave general messages on your home/cell phone about appointments, test results? ☐ Yes ☐ No

Would you permit us to get your medication list from your Pharmacy if you can't remember? ☐Yes ☐No

Do you have any specific restrictions about handling your Protected Health information?
☐No ☐ Yes (specify)

Primary Insurance Information

Primary Insurance company	Employer:
Policy number	Group number

Policy holder ☐Self (if self go to next page) ☐Other (fill next rows):

Policyholder name	Relation to patient	Birth Date*(Month/DD/YYYY)*	Social Security Number
Address (if different from patient)		Phone	Employer

Please go to next page>>

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Secondary Insurance Information			
Secondary Insurance company		Employer:	
Policy number		Group number	
Policy holder ☐ Self (if self go to next page)		☐ Other (fill next rows):	
Policyholder name	Relation to patient	Birth Date *(Month/DD/YYYY)*	Social Security Number
Address (if different from patient)		Phone	Employer

Renewal of patient registration

☐ By checking this box, I attest that there is no material change in my individual patient information, referral/contact information and insurance information from my prior registration_____ (initial/s)

Insurance Benefits: Financial Arrangement

I assign, transfer and send over to Brookhaven Heart PLLC all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. I understand that I am financially responsible for any charges not covered by my insurance company such as co-payments, co-insurances, deductible or returned check processing fees. I also understand that if Physician (s) of Brookhaven Heart PLLC does not have a contract with my insurance, Brookhaven Heart PLLC will submit charges to my insurer on an unassigned basis for services rendered to me. In such event, I understand that my insurer may send the payment directly to me for these services. If I receive such payments and/or correspondences from my insurer for services rendered by Physician (s) of Brookhaven Heart PLLC, I agree to submit these to Brookhaven Heart PLLC. In the event of any default, I understand that I could be referred to collection agency, and be subject to pay interests, collection costs and/or reasonable attorney fees. This authorization shall remain valid until written notice is given by me revoking said authorization.

ATTENTION: This is a legal document. By signing, you agree that you understood and accept the terms on this form

- ✓ **If the patient is 18 years of age or older**, the patient must sign and date the form.
- ✓ **If the patient is 18 years of age or older and incapable of signing**, legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship

  ☐ Legal Guardian ☐ Health care agent
- ✓ **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form unless exception exists under federal law. Please indicate your relationship:

  ☐ Parent ☐ Legal Guardian

Signature *(Required)*	**Date Signed** *(Required) (Month/DD/YYYY)*

Print Name of Person Signing (If not Patient)

** Include completed form in patients' medical records*

Print

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