Frisco Heart and Vascular Institute, P.A.

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name:	First:	MI:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one): Single / Married / Divorced / Widow / Other

Date of Birth:	Sex: ❑ M ❑ F	Social Security Number:	Race: ❑ American Indian ❑ Asian ❑ Black / African American ❑ Hispanic ❑ White ❑ Other

Mailing Address:	City / State / Zip Code:	E-Mail Address:

Primary Phone:	Alternate Phone:	❑ OK to leave message with detailed information ❑ Leave message with call back information only ❑ OK to mail written communication to my address
Occupation:	Employer:	Work Phone:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Location ❑ Yellow Pages / Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance Carrier:	ID / Policy Number:	Group Number:	Primary Policy Holder Name:

Relationship to Patient? ❑ Self ❑ Spouse ❑ Parent ❑ Other ___________________ Co-Pay / Deductible:

Secondary Insurance Carrier:	ID / Policy Number:	Group Number:	Primary Policy Holder Name:

Relationship to Patient? ❑ Self ❑ Spouse ❑ Parent ❑ Other ___________________

EMERGENCY CONTACTS

Name of relative or friend:	Relationship to patient:	Phone Number:
Name of relative or friend:	Relationship to patient:	Phone Number:

PHARMACY INFORMATION

Pharmacy Name:

Address / Intersection: Phone Number:

AUTHORIZATION / CONSENT

The above information is correct to the best of my knowledge. I authorize Frisco Heart and Vascular Institute, P.A. to:

- File an insurance claim(s) on my behalf based on the information I provided and I will receive an Explanation of Benefits (EOB) from my insurance carrier(s) that will detail any payments, deductions, and adjustments per my individual insurance plan's guidelines.
- Request my insurance benefits be paid directly to Frisco Heart and Vascular Institute, P.A. for services rendered at this location.
- Release any information to my insurance company that is required to process my medical claims.
- View my prescription history from external sources.

I certify that I am an adult with appropriate decision making capacity and hereby provide consent for medical treatment by Frisco Heart and Vascular Institute, P.A.

Patient signature: **Date:**