Preventive Cardiology & Internal Medicine Associates, P.L.
3606 Maclay Blvd. Suite 104
Tallahassee, FL. 32312

PATIENT REGISTRATION FORM

PATIENT INFORMATION _**DATE:** _______________________

Patient Name: ____Nickname:_________________________

Address (Physical Location):______________________________City:________________State:_____Zip:________

Address (Mailing):_______________________________________City:________________State:_____Zip:________

Phone(Home):________________(Work):_________________Ext:________Other (Cell):______________________

Sex: Male / Female Birthdate:_____________________ Age:_________________ Marital Status: S M D W

Patient's SS #:________-________-________Employer:____

Employer's Address:____

Emergency Contact:__________________________Relationship:________________Phone:___________________

Referred By:___________________Prev. Doctor________________ Reason for Changing Doctors:______________

INSURANCE INFORMATION

Primary Insurance:____

Type Ins:_____ HMO_____ PPO______ Other Co-Pay Amount:__________ Deductible:____________________

Insured's Name:________________________________ Relationship to Patient:_____________________________

Phone(Home):___________________________________(Work):_________________Ext:_____________________

Insured's SS #:__________-_________-___________ Employer:____

Policy/Contract #:_____________________________ Group #:____

Secondary Insurance:_____________ ____
Type Ins:_____ HMO_____ PPO______ Other Co-Pay Amount:__________ Deductible:____________________
Insured's Name:________________________________ Relationship to Patient:_____________________________
Phone(Home):___________________________________(Work):_________________Ext:_____________________
Insured's SS #:__________-_________-___________ Employer:____
Policy/Contract #:_____________________________ Group #:____

GUARANTOR (Who is Responsible for Payment?)
Name:____
Address:____Apt#:____________________
City:____ State___________Zip:________________________
Phone(Home):___________________(Work):_______________________Ext:______________________________
Guarantor's SS #:_________-__________-___________

FOR CHILDREN
Mother's Name:____ Birthdate:_________/_________/_____
Employer:____ Phone:___________________________
Home Address:____ __ Home Phone:___________________________
Father's Name:____ Birthdate:_________/_________/_____
Employer:____ Phone:___________________________
Home Address:____ __ Home Phone:___________________________
Father's SS #:__________-__________-________

PCAIMA

SPECIAL ASSIGNMENTS/AUTHORIZATIONS (PLEASE READ CAREFULLY)

CONSENT TO TREATMENT:

I hereby consent to and authorize the performance of all appropriate procedures and course of treatment, the administration of all local anesthetic and/or blocks, and any and all medication and technical procedures, which in the judgment of the Healthcare provider attending and consulting may be considered necessary or advisable to treat.

Me ______________________________ -OR- My ________________/______________________

(Print Name) (Relationship) (Print Name)

While a patient of a physician in the employment of Preventive Cardiology & Internal Medicine Associates (PCAIMA). In addition to the above:

- ⇨ I consent to the appropriate disposal by PCAIMA staff of any specimens or other bodily materials removed during technical procedure or for testing purposes.
- ⇨ I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantee has been made as to the results of any therapies and/or procedure(s).

PATIENT'S VALUABLES:

PCAIMA does not accept responsibility for any personal property (monetary or sentimental).

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby certify that the following information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or by any third-party payors is correct. I assign payment to PCAIMA of all benefits due me under the terms of said policies and programs. I assign payment to the physician(s) rendering medical services. I understand that I am required to pay for any health insurance deductibles, coinsurance or any other charges incurred which are not paid by my insurance or other third-party payors together with all costs of collection. If necessary, including a reasonable attorney's fee If collected by or through an attorney at law.

RELEASE OF INFORMATION:

I do hereby authorize Preventive Cardiology & Internal Medicine Associates and any physician examining and/or treating me to release any medical information and records concerning diagnosis and treatment either during inpatient or outpatient treatment for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

HMO ELIGIBILITY GUARANTEE:

I hereby certify that if I am enrolled in an HMO and/or Medipass that I am receiving healthcare services through the primary care physician that I have chosen or have been assigned to me. I understand that if the above is not true or if I am not eligible under the terms of my medical and hospital subscriber health insurance agreement. I am liable for all charges for the services rendered. Also, if the above is not true, **I agree to pay in full for all services received within thirty (30) days of receiving a bill from Preventive Cardiology & Internal Medicine Associates.**

My signature represents that I have read the above and thereby give my agreement and authorization to all of the above:

____ __________________________

Signature Date