# PATIENT REGISTRATION

**Name:** ______________________________________________ **Date of Birth:** ___/___/_____

**Local Address:** ________________________ **City** ______________**State** ______**Zip**_______

**Alternate Address:**___________________________**City**__________**State**_____**Zip**_______

**Home Phone No:** ______________________ **Alternate Phone No:** ____________________

**Employer:** ___________________________ **Work Phone No:** ______________________

**Social Security No:** ____________________ **Sex:** ____ **Marital Status:** ___________________

**Spouse Name:**_________________________ **Spouse Birthdate:**________________________

**Spouse SS#** ___________________________ **Spouse Employer** _______________________

**Referring Physician:** ___________________**Primary Care Physician** ____________________

**Emergency Contact:** _____________________________**Phone:** (     ) ____________________

**How did you hear about us? Friend**___ **Newspaper**___ **TV**___ **Physician**__ **Telephone Book** ___
**Other** _______________________________

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**Primary Insurance Carrier:** _____________________________________________________

**Insured's Name:** _________________________**Insured's Date of Birth:** _____/_____/_______

**Policy Number:** _____________________**Group Number:** ____________________________

**Secondary Insurance Carrier:** ___________________________________________________

**Insured's Name:** _________________________**Insured's Date of Birth:** _____/_____/_______

**Policy Number:** ____________________ **Group Number:** ____________________________

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**I hereby verify that the above information is accurate. I fully acknowledge that payment is based solely on my contract with an insurance company or government agency, and I do agree to pay for services not fully reimbursed by them. I authorize the release of all medical information necessary to process the claim. I authorize all benefits payable to be assigned and made payable to GulfCoast Cardiothoracic and Vascular Surgeons on my behalf. In the event that the procedure billed is deemed noncovered, full payment is not received, my deductible has not been satisfied, or for any reason whatsoever the insurance company does not make full and prompt payment to GulfCoast Cardiothoracic and Vascular Surgeons, I agree to settle the account in full with GulfCoast Cardiothoracic and Vascular Surgeons upon notice of the failure of my insurance company to pay. I authorize the release of any and all of my medical records to any physician and/or hospital participating in my care.**

**Patient Signature:** ______________________________________**Date:** _____/_____/_______