



**NORTH PHOENIX
HEART CENTER**
The Valley's Premier Cardiology Group

REGISTRATION

| | | |
|---|----------------------------|-------------------|
| Section I: | Patient Information | Date _____ |
| Name: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> Last First Middle </div> | | |
| Address: _____ City: _____ State: _____ Zip _____ | | |
| Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____ | | |
| The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Cell phone | | |
| Date of Birth: _____ Social Security Number: _____ [] Married [] Single [] Divorced [] Widowed | | |
| Spouse's Name: _____ Employer _____ Work Phone _____ | | |
| Primary Care Physician: Full Name _____ | | |
| Referring Physician: Full Name: _____ | | |
| Person to contact in case of emergency _____ Phone _____ | | |
| Patient's Email Address _____ | | |

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|---|--------------------------|
| Section II | Responsible Party |
| Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other | |
| Name: _____ Relationship to Patient: _____ | |
| Address: _____ | |
| City: _____ State: _____ Zip: _____ Phone: (_____) _____ | |
| Employer _____ Work Phone (_____) _____ SSN# _____ | |

| | |
|---|------------------------------|
| Section III | Insurance Information |
| Name of Insured _____ DOB _____ Relationship to Patient _____ | |
| SSN#: _____ Name of Employer: _____ Work Phone: (_____) _____ | |
| Address of Employer: _____ City _____ State: _____ Zip _____ | |
| Insurance Company _____ Group # _____ ID# _____ | |
| Ins Co Address: _____ Ins Co. Phone: _____ | |
| ----- DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE FOLLOWING ----- | |
| Name of Insured _____ DOB _____ Relationship to Patient _____ | |
| SSN#: _____ Name of Employer: _____ Work Phone: (_____) _____ | |
| Address of Employer: _____ City _____ State: _____ Zip _____ | |
| Insurance Company _____ Group # _____ ID# _____ | |
| Ins Co Address: _____ Ins Co. Phone: _____ | |

I hereby assign my insurance benefits to be paid to North Phoenix Heart Center, PC. I understand that I am financially responsible regardless of insurance coverage. I also authorize the release of any information required in the processing of insurance claims. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

Patient/Legal Representative: _____ Date: _____