

| Chart Number |
|--------------|
| |

Arrhythmia Consultants, PC

Registration

(This information is needed to properly file your insurance. Please print clearly.)

| Date |
|------|
| |

Patient Information

| Patient's Social Security # |
|-----------------------------|
| |

| Patient's Name | | | | Please circle | |
|----------------|------------|------|--------------------------------------|---------------|--|
| Last Name | First Name | M.I. | preferred prefix | Sex | |
| | | | Mr. Dr. Ms. Mrs. Miss Other:_____ | | |

| Street Address | Birthdate | Age |
|----------------|-----------|-----|
| | | |

| City | State | Zip Code | Home Telephone | Work Telephone |
|------|-------|----------|----------------|----------------|
| | | | | |

| Employer | Employer's Address | Marital Status |
|----------|--------------------|----------------|
| | | |

| E-Mail Address | Name | Other Important Contacts Relationship | Telephone Number |
|----------------|------|--|------------------|
| | | | |

| In case of emergency, who may we contact who does not live with you? | | What is your preferred pharmacy? | |
|--|-----------|----------------------------------|-----------|
| Name | Telephone | Name | Telephone |
| | | | |

Responsible Party

Complete this section if you are a dependent on someone else's insurance.

| Responsible Party's Social Security # |
|---------------------------------------|
| |

| Responsible Party's Name | | | | Please circle | |
|--------------------------|------------|------|----------------------|---------------|--|
| Last Name | First Name | M.I. | preferred prefix | Sex | |
| | | | Mr. Ms. Mrs. Miss | | |

| Street Address | Birthdate | Relationship To Patient |
|----------------|-----------|-------------------------|
| | | |

| City | State | Zip Code | Home Telephone | Work Telephone |
|------|-------|----------|----------------|----------------|
| | | | | |

| Employer | Employer's Address | Marital Status |
|----------|--------------------|----------------|
| | | |

Arrhythmia Consultants, PC

Insurance Information

Please provide our receptionist with your insurance card so that it may be copied. Thank you.

Primary Insurance

| Insurance Company | Insured | Policy # | Group # | Deductible | Co-Pay |
|-------------------|---------|----------|---------|------------|--------|
| | | | | | |

| Street Address for claims: | City | State | Zip | Telephone Number |
|----------------------------|------|-------|-----|------------------|
| | | | | |

If you are a member of a managed care program, please answer the following questions:

If you are hospitalized, what hospital system must you use? _____

Does your insurance plan require referrals to see a specialist? _____

What is the name and telephone number of your primary care provider? _____

Does your insurance plan require precertifications? _____

If yes, for what services? _____

I have checked with my insurance company and verified that the doctor I'm seeing today is a participating provider on my insurance plan. If a referral from another provider is required before seeing the doctors of Arrhythmia Consultants, PC, I agree that it is my responsibility to obtain such a referral. If any charge remains unpaid because Arrhythmia Consultants, PC does not participate in my plan or because I have not obtained a necessary referral prior to treatment, I agree to be personally responsible for the charges.

Patient/Responsible Party

Secondary Insurance

| Insurance Company | Insured | Policy # | Group # | Deductible | Co-Pay |
|-------------------|---------|----------|---------|------------|--------|
| | | | | | |

| Street Address for claims: | City | State | Zip | Telephone Number |
|----------------------------|------|-------|-----|------------------|
| | | | | |

Medical Records Confidentiality

At Arrhythmia Consultants, PC we honor the confidentiality of your medical records. We will not share the contents of these records with family or friends without your express permission. Please sign below if we may leave medical information such as the result of lab test :

With your spouse. Spouse's name: _____ Your signature: _____

On your answering machine. Your signature: _____

Other: _____ Your signature: _____