REGISTRATION FORM

Date _____

Patient Information

Name_____
Last Name First Name Middle Initial Maiden Name

Address_____ Home Phone_____
Street City & State Zip Code

Fax_____ Pager_____ Mobile Phone_____ Email_____

Birthdate_____ Age_____ Marital Status S M W D SS#_____

Employed By_____Occupation_____ Work Phone_____

Address_____
Street City & State Zip Code

Spouse's Name_____ Spouse's SS#_____

Spouse's Employer_____ Spouse's Work Phone_____

In Case of Emergency Contact_____ Phone Number_____

Referred By_____

Name & Phone number of Nearest Relative Not Living With You_____

Information on person responsible for Bill

Guarantor Name _____

Address_____ Home Phone_____
Street City & State Zip Code

Work Phone _____ Employed by_____ Occupation _____

Birthdate_____ SS#_____Relationship to Patient_____

INSURANCE INFORAMTION

Do you have insurance to cover the fees for service rendered? ___ Yes ___No

Primary Insurance		**Secondary Insurance**	
Name of person who Carries the insurance		Name of person who Carries the insurance	
Primary Insurance Name		Secondary Insurance Name	
Primary Insurance Address		Secondary Insurance Address	
Identification #		Identification #	
Group #	Effective Date	Group#	Effective Date
Insured's Date of Birth		Insured's Date of Birth	

Authorized person's signature

I authorize the release of any medical information necessary to process this claim. Additionally, I request Payment (if applicable) of my Medicare benefits either to myself or to the party who accepts assignment. I also authorize payment of medical benefits to Virginia Heart Inc., Dr. Fareeha I. Khan, M.D. for services performed. I understand that I am responsible for payment regardless of insurance coverage.

_____ _____

Signature Date