Brookhaven Heart

New Patient Registration

(Please complete, print, sign and bring at your visit)

Clear Form

Individual information

Name:		DOB: (mm/dd/yyyy)	Sex: ☐ M ☐ F
Social Security Number:		Marital Status: ☐ Single ☐ Married ☐ Other	
Mailing Address of Patient -Street		City	
State	Zip code	Home Phone	Cell Phone
Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other			Refuse to report ☐
Preferred language: ☐ English ☐ Spanish ☐ Other			
Email:		Would you like to receive our e-mail news letter ☐ Yes ☐ No	

Referral and Contact/s information

Primary care Physician		Referring Physician	
Previous Cardiologist	Address		Phone
Pharmacy	Address		Phone
Next of Kin and/or Health care Proxy		Relationship	Phone
Do you have an Advance Directive? ☐ No Advance Directive ☐ Health Care Proxy ☐ Power of Attorney ☐ Living Will			
How did you find us: ☐ Friend ☐ Relative ☐ Doctor ☐ Internet ☐ Advertisement ☐ Insurance book ☐ Hospital visit ☐ Other			
May we leave general messages on your home/cell phone about appointments, test results? ☐ Yes ☐ No			
Would you permit us to get your medication list from your Pharmacy if you can't remember? ☐ Yes ☐ No			
Do you have any specific restrictions about handling your Protected Health information? ☐ No ☐ Yes			

Primary Insurance Information

Primary Insurance company:		Employer:	
Policy number		Group number	
Policy holder ☐ Self (if self go to next page)		☐ Other (fill next rows):	
Policyholder name	Relation to patient	Birth Date*(MM/DD/YYYY)*	Social Security Number
Address (if different from patient)		Phone	Employer:

Please go to next page>>

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Secondary Insurance Information

Secondary Insurance company:		Employer:	
Policy number		Group number	
Policy holder ☐Self (if self go to next section)		☐Other (fill next rows):	
Policyholder name	Relation to patient	Birth Date*(Month/DD/YYYY)*	Social Security Number
Address (if different from patient)		Phone	Employer:

Renewal of patient registration

☐ By checking this box, I attest that there is no material change in my individual patient information, referral/contact information and insurance information from my prior registration (initial/s)

Insurance Benefits: Financial Arrangement

I assign, transfer and send over to Brookhaven Heart PLLC all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. I understand that I am financially responsible for any charges not covered by my insurance company such as co-payments, co-insurances, deductible or returned check processing fees. I also understand that if Physician (s) of Brookhaven Heart PLLC does not have a contract with my insurance, Brookhaven Heart PLLC will submit charges to my insurer on an unassigned basis for services rendered to me. In such event, I understand that my insurer may send the payment directly to me for these services. If I receive such payments and/or correspondences from my insurer for services rendered by Physician (s) of Brookhaven Heart PLLC, I agree to submit these to Brookhaven Heart PLLC. In the event of any default, I understand that I could be referred to collection agency, and be subject to pay interests, collection costs and/or reasonable attorney fees. This authorization shall remain valid until written notice is given by me revoking said authorization

ATTENTION: This is a legal document. By signing, you agree that you understood and accept the terms on this form

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and incapable of signing**, legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship
  Legal Guardian Health care agent
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form unless exception exists under federal law. Please indicate your relationship:
  Parent Legal Guardian

Signature *(Required)*	**Date Signed** *(Required) (MM/DD/YYYY)*
Print Name of Person Signing (If not Patient)	

Include completed form in patients' medical records