# Patient Registration Information

Basic patient details

Referring Phisician

Primary Care Phisician

First name | Initials | Second name

Age | Birthdate

Day | Month | Year

Sex | Martial Status

Social Security #

Responsible Party ( If A Minor )

Patient's Address

Mailing address

City | State | ZIP

Home Phone | Cell Phone

Patient's Work Details

Patient's Employer

Work Address

Work-Phone

City

State

ZIP

Primary Insurance

Primary Insurance

Policy #

Group #

Claim Address

City

State

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Insurance Co Phone #

Subscriber Name

Birthdate

Day

Month

Year

Social

Subscriber's Employer

Address

City | State | Work Phone

Relationship to Patient

Secondary Insurance

Primary Insurance

Policy #

Group #

Claim Address

City | State

Insurance Co Phone #

Subscriber Name

Birthdate

Day | Month | Year

Social

Subscriber's Employer

Address

City | State | Work Phone

Relationship to Patient

Please indentify the Laboratory your Insurance Company requires you to use:

○ Quest ○ LabCorp ○ CDS ○ Hospital ○ Other

Medical Assignment of Benefits: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ocean Heart Group for any services furnished me by Ocean Heart Group. I authorize any holder of medical information about me to release to the Ocean Heart Group Financing Administration and it’s agents any information needed to determine these benefits or the benefits payable for related services.

Patient signature Date

☐ I agree with the above conditions

Assignment of Benefits: I hereby authorize and instruct any insurance companies involved with my healthcare coverage to make payment directly to Ocean Heart Group. This is for the Professional Medical Expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This payment shall not exceed my indebtedness to the above practice, and I have agreed to pay in current fashion any balance if said professional service charges are over and above this insurance portion of payment. A photocopy of this Assignment shall be considered as e&#xfffd;ective and valid as the original. I also authorize the release of any information pertinent to my case to my insurance company, or adjuster involved in the case, unless I have made alternative arrangements, in writing to Ocean Heart Group, with respect to this data.

Patient signature

Date

☐ I agree with the above conditions