THE HEART CENTER OF NORTHERN ANNE ARUNDEL COUNTY, P.A.
1417 MADISON PARK DRIVE, GLEN BURNIE, MD 21061

PATIENT REGISTRATION FORM

TODAYS DATE: ________________ **PHARMACY NAME, ADDRESS, PHONE #:** ______________________________

LAST NAME: ________________________ **FIRST NAME:** ____________________ **MIDDLE:** ____________

DATE OF BIRTH: ________________ **GENDER:** __________ **SOCIAL SECURITY #:** _______ - ______ - _______

RACE:
- ☐ African American / Black
- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Caucasian / White
- ☐ Native Hawaiian / Pacific Islander
- ☐ Other race ________________
- ☐ Decline to answer

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

ETHNICITY:
- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino
- ☐ Decline to answer

LANGUAGE:
- ☐ English
- ☐ Spanish
- ☐ Deaf
- ☐ Other __________

HOME STREET ADDRESS: ____

ZIP CODE: ___________ **CITY:** ______________________ **STATE:** ________ **COUNTY:** ____________

HOME #: ____________________ **WORK #:** ____________________ **CELL #:** ____________________

PRIMARY NUMBER FOR RETURNED CALLS (CHOOSE ONE): ☐ Home # ☐ Work # ☐ Cell #

PREFERRED METHOD FOR ELECTRONIC APPOINTMENT REMINDERS AND NOTIFICATIONS:
☐ Voice message to Home # ☐ Voice message to Cell # ☐ Text message to Cell # ☐ Secured e-mail (enter below)

E-MAIL: __________________________ **EMPLOYER** (for Workers Comp cases): ______________________

OCCUPATION: ____________________ **STATUS:** ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Unemployed

EMERGENCY CONTACT NAME, DOB, RELATIONSHIP AND PHONE #: ________________________________

PRIMARY CARE PHYSICIAN: ______________________ **REFERRING PHYSICIAN:** ______________________

PRIMARY INSURANCE

INSURANCE NAME: __________________ **EFFECTIVE DATE:** ____________ **CO-PAY AMOUNT: $** __________

NAME OF POLICYHOLDER: ____________________ **ID #:** __________________ **GROUP #:** ______________

SECONDARY INSURANCE

INSURANCE NAME: __________________ **EFFECTIVE DATE:** ____________ **CO-PAY AMOUNT: $** __________

NAME OF POLICYHOLDER: ____________________ **ID #:** __________________ **GROUP #:** ______________

PATIENT RIGHT TO PRIVACY / HIPAA / CONFIDENTIALITY

The "Notice of Privacy Practices" provides information about how The Heart Center of Northern Anne Arundel County, P.A., may use and disclose protected health information about you, and is committed to abide by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), by protecting your confidentiality and privacy. My completing, you attest that you have been provided, or had to your availability a printout of the Notice of Privacy Practices.

In the event we need to contact you regarding your care, test results, or appointment information, please complete the following questions.

A message can be left on my home answering machine: Yes ________ No ________
A message can be left with anyone who answers at my home: Yes ________ No ________
A message can be left on your cell telephone: Yes ________ No ________
A message can be left on your work telephone: Yes ________ No ________

Please list all individuals you authorize our office to disclose your health care records to. We cannot release to any one other than those listed on this form, without your written consent:

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

CONSENT TO TREAT

I, the undersigned, voluntarily consent to treatment by the physician(s) and staff of The Heart Center of Northern Anne Arundel County, P.A. (The Practice), to include physical examinations, medical decision making, ordering and performing testing, and prescribing medication, on my behalf that are medically necessary to diagnose and treat my medical condition. I understand that I have the right to revoke this consent, in writing, except where the Practice has already made disclosures under prior consent. I understand that treatment will not be provided to me in the event I alter the policies stated on this document.

ASSIGNMENT OF BENEFITS

I hereby authorize The Heart Center of Northern Anne Arundel County, P.A., to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I also authorize the release of any necessary information, and permit a copy of this authorization be used in such instances.

I certify that I have completed this form to the best of my knowledge. I have read, understand, and agree to all policies of the office. I authorize payment be made directly to The Heart Center of Northern Anne Arundel County, P.A., from my insurance carrier(s) for all services rendered to me for which the Practice accepts assignment. I understand the Practice has the right to refuse treatment to me as permitted by Federal Regulations if I refuse to sign this form. I agree to the terms and conditions herein, and attest that the information provided is true and accurate.

________________________ ________________________ ________________________

Signature of Patient Print Full Name Today's Date