

HALL – GARCIA CARDIOLOGY ASSOCIATES Patient Registration 6.21.11

Today's Date _____ For service at: SLEH UGH Clear Lake

HGCA Physician _____ Referring MD _____

Referring MD Address: _____ Ref Phys Phone: _____

Patient's Name _____
last first middle

Patient's Birthdate ____/____/____ Age ____ Gender M / F Soc Sec # ____-____-____

Patient address: _____ City _____ State _____ ZIP _____

List an available E-mail _____

Patient Drivers License#: _____ State: _____ Work Phone# _____

Patient Home Phone #1: ____-____-____ Cell Phone #1: ____-____-____

INSURANCE INFORMATION: The following is vital to allow us to aid you in insurance claims
PPO HMO POS MEDICARE MEDICAID SELF-PAY (circle one)

Primary Insurance Company: _____ Phone: ____-____-____

Primary Cardholder: _____ Cardholder Birthdate ____/____/____

Cardholder Social Security # ____/____/____

Subscriber ID #: _____ Subscriber Group #: _____

Secondary Insurance Company: _____ Phone: ____-____-____

Secondary Cardholder: _____ Secondary Birthdate ____/____/____

Subscriber Number _____ Secondary Soc Sec # ____/____/____

Subscriber ID #: _____ Subscriber Group #: _____

Relationship to patient (circle one): Self, Spouse, Dependent, Other _____

Emergency Information

Contact _____ Relationship: _____ Phone: ____-____-____

AUTHORIZATION to Pay Benefits

I hereby authorize payment of benefits directly to the physician or HGCA for the Surgical and/or medical services rendered. I am aware of my responsibility to pay non-covered services.

Signature _____ Date _____ Time _____