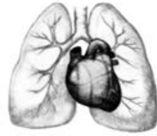

SOUTHWEST
Cardiothoracic Surgeons

Patient Registration

Patient Information

Patient's Name: Last_________________________ First _______________________Middle___________
Social Security #:______-_____-______ Male ____ Female ____ Date of Birth _____/_____/_____
Address: ____
City/State/Zip: ____
Phone #: Daytime (____) _____-_______ Evening (____) _____-_______ Cell (____) _____-________
E-mail address: ____
Emergency Contact: ____ Phone #: (____) _____-_______
Relationship to patient: ____
Physician requesting exam: _____________________ other physician to receive report: _______________

Nursing Home Resident

Do you (the patient) currently reside in a skilled nursing facility? ☐ Yes ☐ No
If yes, please provide the name and phone number of the facility.
Facility Name: ____ Phone #: (_____) ______-_________

Employment Information

Are you (circle one) Employed Unemployed Retired Student
Employer Name: ____
Employer Address: ____

Responsible Party Information

Responsible Party Name: Last ______________________First _____________________Middle________
Social Security #: ______-_____-______ Male _____ Female ____ Date of Birth _____/_____/_______
Phone #: Daytime (____) _____-_______ Evening (____) _____-_______ Cell (____) _____-________
Patient Relationship to Responsible Party: ____

Primary Insurance

(provide your insurance card to the front desk at check- in)

Name of Policyholder: ____________________________ Patient Relationship to Insured: _______________
Policyholder date of birth: _____/_____/_____ Policyholder Social Security #: ______-_____-________
Insurance Company Name: ______________________________________ Phone#: (____) _____-_______
Insurance Company Address: ____
Policy #: ____________________________ Group#: _____________________ Claim#: _________________
Effective date: _____/_____/_____ Accident or Injury Date: ______/______/______

Is this an Auto Accident? ☐ Yes ☐ No Is this a Worker's Compensation claim: ☐ Yes ☐ No
Adjustor: ____ Adjustor phone#: (____) _____-_______
***** You must notify your auto insurance adjuster of your motor vehicle accident for the claim to be processed. Failure to do so makes you personally responsible for your changes.***

Is an attorney involved? ☐ Yes ☐ No
Attorney Name: ____ Phone: (____) _____-_______
Address: ____ City/State/Zip: ____________________________

Secondary Insurance (provide your insurance card to the front desk at check- in)

Name of Policyholder: ____________________________ Patient Relationship to Insured: _____________

Policyholder date of birth: _____/_____/_____ Policyholder Social Security #: ______-_____-________

Insurance Company Name: ______________________________________ Phone#: (____) _____-______

Insurance Company Address: ____

Policy #: ____________________________ Group#: __________________ Claim#: _________________

Effective date: ______/______/______

Acknowledgement of Assignment of Benefits

I hereby acknowledge that I have received medical services from Southwest Cardiothoracic Surgeons. In consideration of the services and treatment rendered, I hereby authorized and direct payment of medical benefits to Southwest Cardiothoracic Surgeons and assign any and all causes of action that I may have against any insurance company (including all coverage for PIP and/or Med-pay, as a result of a vehicular accident), obligated to me by law, statute, or contractual agreement, for payment for such medical services and treatment. I direct my insurer to escrow any personal injury protection and/or medical payment benefits to disputes for services or treatments rendered to me by Southwest Cardiothoracic Surgeons. I also understand that the medical services rendered by Southwest Cardiothoracic Surgeons could have been obtained by other providers but chose to obtain said services and treatments from said facility. I also authorized the release of any pertinent information or medical records to Southwest Cardiothoracic Surgeons, and any other medical provider, insurance company or attorney involved with my medical treatment or case and/or litigation, this is seeking to obtain payment for medical services and treatment rendered by Southwest Cardiothoracic Surgeons or others on its behalf. I hereby direct my insurance company carrier to provide a copy of the PIP log or benefit payout sheet as well as any written explanations as to payments or reductions made or denied or other correspondence pertaining to a claim for services or treatment rendered to me as specified herein. A photocopy of this assignment shall be considered as valid and effective as the original.

____ ______________________

Signature of Patient or Personal Representative Date

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

____ ______________________

Signature of Patient or Personal Representative Date