Carolina Heart Physicians
909 S McPherson Church Road
Fayetteville, NC 28303

Patient Registration Form

Last Name ______________________ First Name_______________________ M.I.___________

Mailing Address____

City:________________________ State:__________________________ Zip Code:___________

Home Phone: _______________________ Cell Phone ________________________________

Date of Birth:____/____/____ Social Security #___________________Marital Status:_______

Race ______________________Sex_________ E-mail Address:___________________________

Insurance Information:

1. Primary Insurance Company Name____

2. **Tricare**: Sponsor's Name_________________ DOB___/____/_____ SSN___________

3. Secondary Insurance Company Name______________________________________

4. Other____

Primary Care Physician_______________________________Phone ______________________

Pharmacy __________________________Phone_________________Fax__________________

Emergency Contact Name_____________ _______ Phone#_____________________________

Relationship to Patient ____

I certify that the above information is true to the best of my knowledge. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I authorize CHP to release any medical information to my insurance carrier that is required to process my claim.

Medicare Beneficiaries**:** I request that payment of authorized Medicare benefits be made to CHP. I authorize any holder of medical information to release to CMS any information needed to determine benefits or benefits payable for related services.

SIGNATURE X ______________________________________ Date__________________________

Release of Medical Information

As part of our effort to comply with the HIPPA Privacy Regulations, we ask that you please provide the name of family members or other persons whom we may release information regarding your general medical condition, financial account, or who has your permission to pick up information you have requested.

Name:_______________________ Relationship:___________________

Name:_______________________ Relationship:___________________

Signature x_________________________Date________________________