Preventive Cardiology & Internal Medicine Associates,P.L.
3606 Maclay Blvd. Suite 104
Tallahassee, FL. 32312

PATIENT REGISTRATION FORM

PATIENT INFORMATION **DATE: _____**

Patient Name: _____Nickname:_____
Address (Physical Location):_____City:_____State:_____Zip:_____
Address (Mailing):_____City:_____State:_____Zip:_____
Phone(Home):_____(Work):_____Ext:_____Other (Cell):_____
Sex: Male / Female Birthdate:_____ Age:_____ Marital Status: S M D W
Patient's SS #:_____-_____-_____Employer:_____
Employer's Address:_____
Emergency Contact:_____Relationship:_____Phone:_____
Referred By:_____Prev. Doctor_____ Reason for Changing Doctors:_____

GUARANTOR (Who is Responsible for Payment?)

Name:_____
Address:_____Apt#:_____
City:_____ State_____Zip:_____
Phone(Home):_____(Work):_____Ext:_____
Guarantor's SS #:_____-_____-_____

FOR CHILDREN

Mother's Name:_____ Birthdate:_____/_____/_____
Employer:_____ Phone:_____
Home Address:_____ __ Home Phone:_____
Mother's SS #:_____-_____-_____
Father's Name:_____ Birthdate:_____/_____/_____
Employer:_____ Phone:_____
Home Address:_____ __ Home Phone:_____
Father's SS #:_____-_____-_____

INSURANCE INFORMATION

Primary Insurance:_____
Type Ins:_____ HMO_____ PPO_____ Other Co-Pay Amount:_____ Deductible:_____
Insured's Name:_____ Relationship to Patient:_____
Phone(Home):_____(Work):_____Ext:_____
Insured's SS #:_____-_____-_____ Employer:_____
Policy/Contract #:_____ Group #:_____
Secondary Insurance:_____ _____
Type Ins:_____ HMO_____ PPO_____ Other Co-Pay Amount:_____ Deductible:_____
Insured's Name:_____ Relationship to Patient:_____
Phone(Home):_____(Work):_____Ext:_____
Insured's SS #:_____-_____-_____ Employer:_____
Policy/Contract #:_____ Group #:_____