NEW PATIENT REGISTRATION FORM

PLEASE PRESENT YOUR INSURANCE CARD(S) & PHOTO ID FOR COPIES TO BE MADE.

Name: ____ SSN: ______________
(Last) (First) (MI)

Address: ______________________________ City: ______________ State: ________ Zip: __________

Home Ph: ____________________ Cell Ph: ____________________ Work Ph: ____________________

Circle One: Male Female   Marital Status: M S W D   Email: ______________________________

Responsible Party's Name: ____
(Last) (First) (MI)

Social Security Number: ___________________________ Date of Birth: ___ /___ /______

Next of Kin Name: _________________________________ Phone: __________________________

Emergency Contact Name: __________________________ Phone: __________________________

Referring Physician Name: _________________________ Phone: __________________________

Family Doctor Name: ______________________________ Phone: __________________________

Preferred Pharmacy: ____________________________ Preferred Lab: ________________________

How did you hear about us? ☐ **Physician** ☐ **Current AHC Patient** ☐ **Newspaper** ☐ **Website** ☐ **Phone Book**

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification or second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

Race (circle): African American American Indian Arabic Asian Caucasian Hispanic Indian Unknown

Ethnicity: African American Chinese Columbian Cuban Dominican Haitian Indian Vietnamese

Preferred Communication Method (circle): Home Phone Cell Phone Work Phone Email Letter

Ownership Disclosure: In the event you and your physician choose the Heart Hospital Baylor Plano (HHBP) for your cardiovascular care, the HHBP is the first and only freestanding, full-service hospital dedicated solely to heart and vascular care in North Texas. It was created through a partnership between Baylor Regional Medical Center at Plano and 86 cardiovascular specialists, including your physician. This notice is to inform you that, through this partnership, your physician has a financial ownership interest in the HHBP.
If you are considering services at Hopkins County Memorial Hospital, we hereby notify you that your physician may have an ownership interest in the cardiovascular services provided therein.

Assignment & Release:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financial responsible for all non-covered services, copays, deductibles and/or coinsurance.
- I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process a claim.
- I authorize my provider's office to contact me by phone to remind me of my appointments.
- I understand that a fee may be assessed if I do not show up for my appointment.
- I authorize my provider's office to download my prescription medical history into my clinical chart.

PATIENT SIGNATURE: ____