

# New Patient Registration and Intake Form

*Pham Cardiovascular Center*

## PATIENT INFORMATION

Date	Name			
Social Security	Sex	Date of Birth		
Street address			City	
State	Zip	Primary Phone	<input type="checkbox"/> Cell	<input type="checkbox"/> Home
Alternative Phone	<input type="checkbox"/> Cell	<input type="checkbox"/> Home	Email	
Race:	White	African American	Decline to Specify	Other:
Ethnicity:	Not hispanic or Latino	Hispanic or Latino	Decline to specify	Other:

## INSURANCE INFORMATION DO NOT FILL OUT IF PRESENTING CARD TO BE COPIED

Primary Insurance:		Insurance ID No:		
Group No:	Insured's Name:		Insured's Date of Birth:	
Secondary Insurance:		Insurance ID No:		
Group No:	Insured's Name:		Insured's Date of Birth:	

## EMERGENCY CONTACT INFORMATION

Emergency Contact:	Relationship:
Phone:	

**I authorize Pham Cardiovascular Center to release my protected health information to the following people on my behalf.**

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

## ADVANCED DIRECTIVE

Do you have a DNR (do not resuscitate order)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a designated medical decision maker in case you cannot make medical decisions on your own?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, who is designated?		

**PHARMACY**

Pharmacy:	Pharmacy Phone Number:
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Pharmacy Address:

**PRIMARY CARE**

Primary Care Physician:

**MEDICATION CONSENT**

I voluntarily consent to provide Pham Cardiovascular Center access to and use of my prescription medication history history from other healthcare providers or third-party pharmacy benefits payors for treatment purposes. I understand that my prescription history may be viewable by my providers and staff here. **(PLEASE SIGN)**

Accept:

Decline:

**CONSENT**

I hereby request and consent to routine and medical care for the patient including all routine examinations, tests, photographs and other procedures.

**ASSIGNMENT OF BENEFITS:** I hereby assign to PHAM CARDIOVASCULAR CENTER, for services provided, all coverage or other benefits available under any government program, insurance policy or plan, and other benefit program, and I direct that all benefits be paid directly to PHAM CARDIOVASCULAR CENTER.

**FINANCIAL AGREEMENT:** We are contractually required to collect your copayment at the time of service. If your account is 120+ days overdue and you have not made payment arrangements, you may be referred to collections. Patients who do not have health insurance, payment for services rendered is required at the time of service unless arrangements have been made prior.

**MEDICAL RECORD RELEASE:** I authorize release of all or any part of the patient 's medical record to any person or entity which may be responsible to pay for any portion of the charges incurred. If you must cancel an appointment with our office, we ask that you notify us at least 24 hours in advance. There is a \$25.00 fee for No Shows on a routine visit and a \$100.00 fee for a No Show for procedures. These fees are due prior to scheduling your next appointment.

**EMAIL:** I authorize PHAM CARDIOVASCULAR CENTER to send Appointment Reminders electronically via Email.

**TEXT MESSAGE:** I authorize PHAM CARDIOVASCULAR CENTER to send Appointment Reminders electronically via text message to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply. **VOICE MESSAGE:** I authorize PHAM CARDIOVASCULAR CENTER

to contact me for Appointment Reminders via voice messaging. If I am unavailable to answer the telephone, I give PHAM CARDIOVASCULAR CENTER permission to leave a message on my answering machine or with the person answering the telephone. I also acknowledge that I have been provided the Notice of Privacy Practices. This form has been fully explained to me, I understand its content, I have had full opportunity to ask questions concerning this form and any questions I've asked have been answered to my satisfaction.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_