CMH Cardiology and Pulmonology
Patient Registration

PLEASE PRINT CLEARLY

Patient Name: _____ SSN : _____

First Name MI Last Name

Date of Birth: _____ Male ___ Female ___ Marital Status: _____ Race: _____

Mailing Address: _____

City/State/Zip Code: _____ Email Addres: _____

Preferred Method of Communication: ____ Home Phone ____ Cell Phone ____ Work Number ____ Patient Portal

Home Phone: _____ Cell Phone: _____ Work Number: _____

Employer: _____

Spouse's Name: _____ DOB: _____

Responsible Party: ____ Self ____Spouse ____Parent ___Other: _____ (Please specify)

If patient is a minor, are parents: ____Married ____Divorced Custodial Parent: _____

Emergency Contact: _____ Contact Number: _____

Relationship to patient: _____

Referring Physician: _____ **Primary Care Physician:** _____

Pharmacy: _____

PLEASE PRESENT INSURANCE CARD(S) AND PHOTO ID FOR YOUR CHART

Primary Insurance Company: _____ Policy No.: _____

Insured Name: _____ Group No." _____

Insured DOB: _____ Relationshipt to Patient: _____

Secondary Insurance Company: _____ Policy No.: _____

Insured Name: _____ Group No." _____

Insured DOB: _____ Relationshipt to Patient: _____

I hereby authorize the office of CMH Cardiology and Pulmonology to release my medical information during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, co-payment, deductible and non-covered services. If I have Medicare, I also request payment of authorized Medicare benefits be made either to me or on my behalf to CMH Cardiology and Pulmonology for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

» _____ _____

Patient Signature **Date**

I authorize CMH Cardiology and Pulmonology to treat me and use my personal health information for healthcare operations.

» _____ _____

Patient Signature (or responsible party if patient is unable to sign) **Date**

Patient Acknowledgement

I have been given a copy of the VCU Community Hospital Notice of Privace Practice that describes how my health information is used and disclosed.

» _____ _____ _____

Patient Signature (or responsible party if patient is uanble to sign) **Printed Name** **Date**

***If signed by legal representative and/or guardian, list relationship to patient: _____