

**FIRST COAST CARDIOVASCULAR INSTITUTE, P.A.  
PATIENT REGISTRATION FORM**

Patient ID # \_\_\_\_\_ Date \_\_\_\_\_

Last Name \_\_\_\_\_ FirstName \_\_\_\_\_ Middle Initial \_\_\_\_\_

Sex: F \_\_\_\_\_ M \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

email \_\_\_\_\_ Social Security# \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If married Spouse's Name \_\_\_\_\_

Do we have permission to:

Leave a message on your answering machine at home? Yes \_\_\_ No \_\_\_

Leave a message at your place of employment? Yes \_\_\_ No \_\_\_

Discuss your medical condition with any member of your household? Yes \_\_\_ No \_\_\_

If yes, whom? \_\_\_\_\_ Relationship \_\_\_\_\_

**EMERGENCY CONTACT OUTSIDE OF THE HOME**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Other Contact Phone \_\_\_\_\_

**REFERRING PHYSICIAN Name** \_\_\_\_\_

Office Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

**Do you have Medicare:** Yes \_\_\_ No \_\_\_ Is it your primary insurance Yes \_\_\_ No \_\_\_

Medicare ID # \_\_\_\_\_

Is it a Medicare HMO: Yes \_\_\_ No \_\_\_ Which one: Aetna \_\_\_ Humana \_\_\_ Health Excel \_\_\_ AVMED \_\_\_ Other \_\_\_\_\_

**Do you have Medicaid:** Yes \_\_\_ No \_\_\_ Is it your primary insurance Yes \_\_\_ No \_\_\_

Medicaid ID # \_\_\_\_\_ Is it a Medicaid HMO Yes \_\_\_ No \_\_\_

Which one: Healthease \_\_\_ Medipass \_\_\_ Floridian Care: \_\_\_ Other: \_\_\_\_\_

**Primary Insurance Co.** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Member Ins. ID# \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured if other than patient \_\_\_\_\_

Relationship to Patient: \_\_\_ Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_\_\_

Insured Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Do you have secondary insurance: Yes \_\_\_ No \_\_\_

Medicare: \_\_\_ Medicare HMO \_\_\_ Medicaid \_\_\_ Medicaid HMO \_\_\_ Other \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Member Ins. ID# \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured if other than patient \_\_\_\_\_

Relationship to Patient: \_\_\_ Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_\_\_

Insured Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_

How did you hear about our practice \_\_\_\_\_

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

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_