Horizon Cardiology

10-14 Saddle River Road
Fair Lawn, NJ 07410
(551) 246-3008

Patient Registration Form

Please Provide Insurance Card for Verification

DATE: _____________

NAME OF PATIENT: ____

LAST FIRST M.I.

SEX: M / F AGE: _____ DATE OF BIRTH: ___________ SOC. SECURITY #: ________________

DRIVERS LICENSE #: ___________________________ STATE: _______ MARITAL STATUS: _____________

HOME ADDRESS: ___________________________ CITY: _______________ STATE:______ ZIP: _________

HOME TELEPHONE: _________________________ DAYTIME NUMBER: ________________________________

CELL: ____________________________ EMAIL: _________________________________

EMPLOYER: _______________________________ OCCUPATION: ______________________________________

EMPLOYER ADDRESS: ___________________________ CITY: ____________ STATE: ______ ZIP: _________

SPOUSE NAME: _______________ DATE OF BIRTH: _________ SPOUSES SOC. SECURITY #: _______________

SPOUSE EMPLOYER: __________________________ SPOUSE WORK PHONE: _____________________________

REFERRING PHYSICIAN: ________________________________ PHONE: ___________________________

PCP: ________________________________ PHONE: ___________________________

EMERGENCY CONTACT: ____________________________ RELATIONSHIP TO PATIENT: __________________

HOME TEL: ___________________ WORK TEL: ______________________ CELL: __________________________

PRIMARY INSURANCE: _________________________ NAME OF INSURED: [ ] SELF OTHER:______________

ID #: __________________________ GRP #: ________________________ POLICY #: ________________________

SECONDARY INSURANCE: ______________________ NAME OF INSURED: [ ] SELF OTHER:_____________

ID #: __________________________ GRP #: ________________________ POLICY #: ________________________

DO YOU BELONG TO: [ ] MEDICARE [ ] MEDICARE / HMO [ ] HMO [ ] PPO [ ] MEDICAID

RACE: [ ] Hispanic American [ ] Hispanic Other [ ] Indian [ ] Alaskan Native [ ] Asian [ ] Black
[ ] African American [ ] Native Hawaiian [ ] Other Pacific Islander [ ] White [ ] Other

PRIMARY LANGUAGE: ____

I hereby authorize payment of my medical and surgical insurance benefits to Horizon Cardiology. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles agree designated by my insurance company or health plan, I agree to pay them to Horizon Cardiology. I authorize Horizon Cardiology to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Patient Signature: ____ Date: __________________

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In general, the HIPAA privacy rule gives individuals the right to request a restriction on used and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

This office will generally contact patients by written communication or phone calls. We will send letters or call the number that you have provided us on your patient sheet.

Home Telephone (__) _____________
[ ] Okay to leave message with detailed information. [
] Leave message with call back number only

Cellular Telephone L_) ____________
[ ] Okay to leave message with detailed information. [
] Leave message with call back number only

Work Telephone (__) ______________
[ ] Okay to leave message with detailed information [
] Leave message with call back number only
[ ] Okay to fax to (__) ______________

Written Communication
[ ] Okay to mail to my home address [
] Please mail to another address:
The Privacy Rule Generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply for used or disclosures made pursuant to an authorization requested by the individual.

 [Name ____]

Record of Disclosures of Protected Health Information

I, ______________________ authorize the office of Horizon Cardiology, to contact the following person(s) in regard to my medical information.

___________________________________	___________________________________
Name/Relationship	Telephone Number
___________________________________	___________________________________
Name/Relationship	Telephone Number
___________________________________	___________________________________
Patient Signature	Patient Name
___________________________________	___________________________________
Birth Date	Date

10-14 Saddle River Rd ♥ Fair Lawn, NJ 07410 ♥ Phone: (551) 246-3008 ♥ Fax: (201) 703-1100