

ALDERFER & TRAVIS CARDIOLOGY

670 LAWN AVENUE, SUITE 3A
SELLERSVILLE, PA 18960
PHONE: 215-257-9500
FAX: 215-257-3578

PATIENT REGISTRATION

PATIENT'S NAME: _____ DATE: _____
STREET: _____ HOME PHONE: _____
CITY: _____ STATE: _____ ZIP: _____ SEX: _____ AGE: _____
BIRTH DATE: _____ MARITAL STATUS: S M W D SEP
SOCIAL SECURITY # _____ OCCUPATION: _____
EMPLOYER: _____ WORK PHONE: _____
NAME SPOUSE: _____ WORK PHONE: _____
EMERGENCY CONTACT: _____ PHONE: _____
RELATIONSHIP: _____
FAMILY PHYSICIAN: _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____
SECONDARY INSURANCE _____

FOR PRIVATE INSURANCE:

I here by authorize the insurance companies listed pay directly to Alderfer & Travis Cardiology for any services furnished to me by any physician in said practice; otherwise, payable to me under terms of my insurance. I hereby authorize photocopies of this authorization to be considered valid and effective as the original.

PATIENT'S SIGNATURE: _____ DATE: _____

LIFETIME MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits pay directly to Alderfer & Travis Cardiology for any services furnished to me by any physician in said practice; otherwise, payable to me under terms of my insurance. 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 or the benefits payable for related services.

PATIENT'S SIGNATURE: _____ DATE: _____

MEDIGAP:

I request that payment of authorized Medigap benefits pay directly to Alderfer & Travis Cardiology for any services furnished to me by any physician in said practice; otherwise payable to me under terms of my insurance. I authorize any holder of medical information about me to release to _____ (ins co) and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE: _____ DATE: _____

PRINTED NAME: _____