

REGISTRATION

Please Print

HEARTLAND MEDICAL SERVICES, P.C.

251 Richmond Hill Road • Staten Island, NY 10314

358 Arden Avenue • Staten Island, NY 10312

Date: _____ **PATIENT INFORMATION** Phone: _____

Patient Name: _____
Last First Initial

Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birthdate: _____ S/S# _____ - _____

Single Married Widowed Separated Divorced How did you hear about us? _____

Employed by: _____ Occupation: _____

Business Address: _____ Phone: _____
City State Zip

Notify In Case of Emergency: _____ Phone: _____

PRIMARY INSURANCE

Person Responsible For Account: _____
(Subscriber Name) Last First Initial

Relationship to Patient: _____ Birthdate: _____ S/S#: _____ - _____

Address (If different from patient's): _____
City State Zip

Phone: (_____) _____ - _____

Employed by: _____ Occupation: _____

Business Address: _____ Phone: _____

Insurance Company: _____

ID#: _____ Group #: _____ Category #: _____

If College Student 19 - 23 Years, Covered By Parents' Insurance

College: _____ Enroll Date: _____ Anticipated Grad Date: _____

ADDITIONAL INSURANCE

Is Patient Covered by Additional Insurance Yes No Subscriber: _____

Relation to Patient: _____ Birthdate: _____ SS#: _____ - _____

Address (If different from patient's): _____
City State Zip

Phone: (_____) _____ - _____

Subscriber Employed By: _____ Bus. Phone: _____

Insurance Company: _____

ID#: _____ Group #: _____ Category #: _____

ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for all charges not covered by my insurance carrier. I hereby authorize payment directly to the above named professional corporation or physician. I give Heartland Medical Service, PC, authorization to use my credit card to pay any charges not covered or any charges denied by my insurance carrier, but not to exceed the regular and customary charges for the service provided.

Signature: _____ Date: _____

MEDICARE

HEARTLAND MEDICAL SERVICES, P.C.

W5A401

I request that payment of Medicare benefits be made on my behalf to the physician or physician group named above for services rendered to me. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature

Date