Daytona HEART Group

PLEASE PRINT

Name:______________________________________________________________ Sex: _____

Date of Birth:______________ Race:_______ Social Security No. ____________________

Local Address: ______________________________________________________________

City:__________________________________________________ State:_____ Zip:________

Telephone: _________________________________ Cell Phone:________________________

Email Address: ____________________________________________

Northern Address: ___________________________________________ Date(s):__________

City:__________________________________________________ State:_____ Zip:________

Telephone: _________________________________

Primary Care Doctor:__________________________________________________________

Primary Pharmacy Name: _______________________________________________________

Primary Pharmacy Address: _____________________________________________________

Employer:___________________________________ Telephone:_______________________

Address:_____________________________________________ City: ___________________

Marital Status:__________________ Spouse's Name: ________________________________

Person to Notify other than spouse: _______________________________________________

Address: __________________________________________________________________

City:__________________________________________________ State:_____ Zip: ________

Name of Insurance Company: ____________________________________________________

Policy or Certificate No. ________________________________________________________

Name of Secondary Insurance Company: _____________________________________________

Policy or Certificate No. ________________________________________________________

*** PLEASE PROVIDE A COPY OF YOUR INSURANCE CARDS FOR FILING OF YOUR I NSURANCE . THANK YOU!***

**CERTIFICATION FOR PAYMENT FOR ALL INSURANCES**

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct . I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurance.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED . I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT.

Signed: _____________________________________________________ Date:____________