

REGISTRATION FORM
RUDOLPH MOREIRA, M.D.

IT IS THE PATIENT'S RESPONSIBILITY TO MAKE SURE REFERRALS REQUIRED BY YOUR POLICY ARE DONE BY YOUR PRIMARY DOCTOR PRIOR TO TODAY'S VISIT.

PLEASE PRINT CLEARLY:

PATIENT NAME _____ SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ WORK _____ CELL _____

DO WE HAVE APPROVAL TO LEAVE MESSAGES AT THESE NUMBERS? Y N DATE OF BIRTH _____ AGE _____

PLEASE CIRCLE:

SEX: M F MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED SEPARATED

NEAREST RELATIVE _____ RELATION _____ PHONE _____

WHO REFERRED YOU TO THIS OFFICE? _____

WHO IS YOUR PRIMARY DOCTOR? _____

CARDIOLOGIST: _____

INSURANCE INFORMATION **YOU ARE RESPONSIBLE FOR TELLING US WHO TO BILL FOR YOUR CLAIMS PAYMENT**
****WE MUST HAVE A COPY OF YOUR INSURANCE CARDS TODAY OR PAY FOR TODAY'S SERVICES****

PRIMARY INSURANCE CARRIER (PAYS FIRST) _____

NAME OF POLICY HOLDER _____ THEIR EMPLOYER _____

POLICY HOLDER'S DATE OF BIRTH: _____ POLICY HOLDER'S SS# _____

SECONDARY INSURANCE CARRIER _____

NAME OF POLICY HOLDER _____ THEIR EMPLOYER _____

POLICY HOLDER'S DATE OF BIRTH: _____ POLICY HOLDER'S SS# _____

IS THIS A WORK RELATED INJURY OR ILLNESS? YES _____ NO _____

PLEASE REMEMBER, YOU ARE ACCEPTING RESPONSIBILITY TO PAY ALL PERCENTAGES, DEDUCTIBLES, COPAYS AND ANY DENIED CLAIMS DUE TO PROCEDURES YOU REQUEST THAT YOUR POLICY DEEMS NOT A MEDICAL NECESSITY, NONCOVERED PROCEDURES, OR YOU DID NOT OBTAIN FORMAL REFERRAL FOR.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, Aetna, private insurance, and other health plans to Rudolph Moreira, M.D.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

IF YOU ARE INSURED BY A MANAGED CARE PLAN THAT REQUIRES YOUR PRIMARY CARE DOCTOR TO SUBMIT FORMAL REFERRAL TO THE INSURANCE COMPANY, IN WRITING, AND WE HAVE NOT YET RECEIVED CONFIRMATION THE REFERRAL HAS BEEN DONE, YOU MUST PAY FOR TODAY'S VISIT. **DO NOT LEAVE ANY INFORMATION FIELDS BLANK!**

SIGNED _____ DATE _____

***** PLEASE BRING YOUR INSURANCE CARD AND YOUR COPAYMENT TO THE FRONT DESK*****