Patient Registration Form (Please Print) **Heart Specialists of Central New Jersey, LLP**

Patient Information

Patient's Last Name: ______________ First Name: ______________ MI: ______

Street Address: ______________ Apt # ______ City ______________ State ______ Zip ______

Home Phone #( ) ______________ Work Phone # ( ) ______________ Ext. ______ Cell Phone # ( ) ______________

Social Security # ________-________-________ Date of Birth: ______/______/______

Gender: ☐M ☐F Marital Status: ☐Single ☐Married ☐Widow ☐Separated

Emergency Contact: ______________ Relationship: ______________ Telephone # ( ) ______________

Reason for Initial Visit: ______________

Name of Referring Doctor/Person: ______________ Address: ______________

City ______________ State ______ Zip ______ Ref Doctor Telephone # ( ) ______________

Employer Information

Name of Employer: ______________ Address: ______________

City ______________ State ______ Zip ______ Telephone # ( ) ______________

May we contact you at work? ☐Yes ☐No Occupation: ______________

Guarantor Information

Responsible Party for Bill(s)

Guarantor's Name: ______________ Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other ______

Address: ______________ City ______________ State ______ Zip ______

Employer: ______________ Address ______________ City ______________ State ______ Zip ______

Work Phone # ( ) ______________ Ext. ______ Home Phone # ( ) ______________

Insured Date of Birth: ______/______/______ Insured S.S. # ________-________-________

Primary Insurance

Primary Insurance Name: ______________ Telephone # ( ) ______________

Address: ______________ City ______________ State ______ Zip ______

Policy# ______________ Grp# ______________ Co-pay Amt $ ______ Effective Date ____/____/____

Name of Insured: ______________ Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other ______

Insured Date of Birth: ______/______/______ Insured S.S. # ________-________-________

Secondary Insurance

Secondary Insurance Name: ______________ Telephone # ( ) ______________

Address: ______________ City ______________ State ______ Zip ______

Policy# ______________ Grp# ______________ Co-pay Amt $ ______ Effective Date ____/____/____

Name of Insured: ______________ Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other ______

Insured Date of Birth ______/______/______ Insured S.S.# ________-________-________

Authorization

I, the undersigned, certify that I (or my dependent) have insured coverage with______________________________ and assign directly Drs. Kominos, Gutowski, Beauregard and/or Awasthi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also understand that there will be a $25.00 fee if my account must be sent to collections. I authorize the use of this signature on all insurance submissions.

I also understand that if I am unable to make a scheduled appointment, I must give 24 hours notice to the office. A $25.00 charge will be assessed for missed appointments that are not cancelled 24 hours in advance.

X____
Patient Signature

____
Date