Southern Cardiovascular Care, PC

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Dothan, AL 36301
Phone: 334 699-8900
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PATIENT REGISTRATION FORM

Name: (Last)_____(First)_____(MI)_____

SSN: _____ - _____ - _____ Marital Status – (Circle) Single Married Divorced Widowed

Sex: _____ M _____F (Title) _____ Date of Birth:_____/_____/_____

Ethnic Group – (Circle one) African-American Hispanic Caucasian Asian Other (Specify) _____

Address: _____City _____ State _____ Zip _____

Home Phone : _____ Cell Phone: _____ Work Phone: _____

Emergency Contact – Name: _____ Phone: _____Extension _____

Are you employed: _____ Y _____ N / Are you a Student: _____ Y _____ N / _____ Full- Time _____Part-Time

Patient Employer: _____ Employer Phone: _____

Person responsible for payment of this account will be:

Patient _____ Parent: _____ Other: (Specify) _____

Name: (Last) _____ (First)_____ (MI) _____

Address: _____City _____ State _____ Zip _____

Home Phone : _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Employer Phone: _____ SSN: _____ - _____ - _____

PRIMARY INSURANCE INFORMATION

Subscriber Name: (First) _____ (MI) _____ (Last) _____

Place of Employment :
_____

Subscriber SSN: _____ - _____ - _____ Group Number: _____ ID Number _____

Subscriber relationship to patient - _____ Self _____ Spouse _____ Child / Subscriber Date of Birth _____/ ____/_____

Subscriber Sex: M _____ F _____

SECONDARY INSURANCE INFORMATION

Subscriber Name: (First) _____ (MI) _____ (Last) _____

Place of Employment :
_____

Subscriber SSN: _____ - _____ - _____ Group Number: _____ ID Number _____

Subscriber relationship to patient - _____ Self _____ Spouse _____ Child / Subscriber Date of Birth _____/ ____/_____

Subscriber Sex: M _____ F _____

I have reviewed the above information and, to the best of my knowledge, it is a correct and complete
Patient/Guardian Signature _____ Date _____

Specializing in comprehensive Heart and Vascular care