Suffolk Cardiovascular Consultants, PC
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CARDIOLOGY

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PATIENT REGISTRATION (PLEASE PRINT):

NAME: _____ Soc.Sec. #_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ HOME PHONE: _____ WORK PHONE_____

CELL: _____ EMAIL: _____

SEX M F AGE: _____ BIRTHDATE: _____ SINGLE MARRIED

EMERGENCY CONTACT: _____ PHONE: _____

PATIENT EMPLOYER: _____

WORK ADDRESS: _____ PHONE: _____

PRIMARY CARE MD: _____ PHONE: _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

POLICY NUMBER: _____ POLICY NUMBER: _____

NAME OF INSURED (if not patient): _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP CODE:_____

BIRTHDATE: _____ SOC. SEC.# _____ EMPLOYER: _____

I understand that I am receiving medical services from this office under the provisions of my managed care plan. I will be financially responsible for all deductibles, co-pays and co-insurances under the terms of my insurance contract. If my insurance plan requires a valid referral to receive medical care, I understand that it is my responsibility to provide such a referral. If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balances on my account. If my insurance plan is not accepted by this office, or is of the "indemnity type", I understand that I am financially responsible for all balances remaining after payment of insurance benefits. I hereby authorize and assign directly to Dr. Daniel Landolphi all benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I understand that I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

SIGNATURE: _____ PRINT: _____ DATE: _____