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Comprehensive Cardiovascular Center
Vein Center
Sleep Medicine Clinic

Patient Registration Form

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City, ST: _____

Zip code: _____ DOB: ___/___/___ SSN: ___-___-___ Gender: _____

Contact #: _____ Work #: _____ eMail: _____

Referred by: _____ PCP: _____

Employer Information

Employer Name: _____ Occupation: _____

Address: _____ City, ST: _____ Zip: _____

Insurance Information (Primary)

Carrier: _____ ID #: _____ Group #: _____

Insured: _____ DOB of Insured: ___/___/___

Insurance Information (Secondary)

Carrier: _____ ID #: _____ Group #: _____

Insured: _____ DOB of Insured: ___/___/___ Rel to Insured: _____

Emergency Contact

Name: _____ PH #: _____

Authorization/Disclosure

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Orion Medical to apply for benefits on my behalf for covered services rendered by him/her. I request that payment from my insurance company be made directly to *Orion Medical*. I also authorize consent for treatment for any and all medical services performed. The authorization may be revoked by either me or my insurance carrier at any time in writing.

Signature: _____ Date: _____