BAY AREA HEART
Cardiovascular Center of Excellence

Dr. Rakesh Shah · Dr. Jinesh Shah · Dr. Francis Uricchio · Dr. Andrew Badalamenti

NEW PATIENT REGISTRATION

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____ Gender: _____

Marital Status: (Please circle one) S M D W SSN: _____

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Employer: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Family Physician: _____ Referring Physician: _____

Family Physician Phone#: _____ Referring Physician Phone#: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Pharmacy Name: _____ Address: _____ Phone: _____

RESPONSIBLE PARTY (If different from patient)

Name: _____ Date of Birth: _____ SSN: _____

Home #: _____ Work #: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Policy Holder Name:	Policy Holder Name:
Member ID #	Member ID #
Relationship to Policy Holder:	Relationship to Policy Holder:

PLEASE SIGN THE FOLLOWING STATEMENTS:

I authorize payment of medical benefits to the named provider for professional services rendered. I authorize the release of any medical information necessary to process the claim. I understand that I am financially responsible for any balance. I have been given a copy of the patient's rights and privacy act.

SIGNATURE: _____ *DATE*: _____

I hereby authorize my test results to be left on the answering machine at the following phone number: _____
I authorize my test results to be given to the following person:
Name: _____ Phone #: _____

SIGNATURE: _____ *DATE*: _____

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