HALL-GARCIA CARDIOLOGY ASSOCIATES

Patient Registration

Today's Date ___________ For services at: □ CHI St. Luke's □ UGH □ Clear Lake

HGCA Physician ___________________________ Referring MD ________________________

Patient's Name __________________________, ________________________, ___________
last fist middle

Patient's Birthdate _____ Age____ Gender M / F Soc. Sec. # ___________________________

Patient address ____________________________ City ___________ State ________ Zip _______

List as available E-mail ____

Patient Driver's License # ______________ State: ____ Work Phone # _______________

Patient Home Phone #1 _____________ Cell Phone #1 __________

Insurance information: The following is vital to allow us to aid you in insurance clams

PPO HMO POS MEDICARE MEDICAID SLEF-PAY (circle one)

Primary Insurance Company: __________________ Phone: ______________

Primary Cardholder: _________________________Cardholder Birthday _______

Subscriber ID # ______________________________ Subscriber Group#: ____________________________

Secondary Insurance Company: __________________ Phone ________________________________

Secondary Cardholder: _________________________Secondary Birthday ______ _______

Subscriber Number____________________________ Secondary Soc. Sec # _________

Subscriber ID #:______________________________ Subscriber Group # ______________________

Relationship to patient (circle one) Self, Spouse, Dependent, Other ____________

Emergency Information

Contact _______________Relationship_________ Phone ___________________

AUTHORIZATION to Pay Benefits

I hereby authorize payment of benefits directly to physician or HGCA for Surgical and/or medical services rendered I am aware of my responsibility to pay non-covered services.

Signature: ______________________________ Date: __________________ Time:______________