



Associates In Cardiology

624 Chamberlin Avenue
Frankfort, KY 40601
Phone: (502) 227-2285

Registration and Health Assessment

Date Completed : _____

This information will be kept confidential.

PATIENT INFORMATION						
NAME Last		First	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	SSN
Home Phone #			Cell Phone #	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
Home Address		Street	City	State	ZIP	
E-Mail Address	Emergency Contact: Name		Phone	Relationship		
Responsible Party's Employer's Name		Address	City	State	ZIP	Work Phone
Education: Check highest level completed			<input type="checkbox"/> Grade School	<input type="checkbox"/> Jr. High	<input type="checkbox"/> High School / GED	<input type="checkbox"/> College
INSURANCE INFORMATION						
Person Responsible for Payment:			<input type="checkbox"/> Patient	<input type="checkbox"/> Other		
If Other:	Name:			SSN:	DOB:	
Primary Insurance:						
Id Number:			Group Number:			
Secondary Insurance:						
Id Number:			Group Number:			
AUTHORIZATION FOR RELEASE OF INFORMATION						
Please list below the individuals with whom we have your permission to discuss the content of your entire medical file. (PRINT)						
	<u>Name</u>		<u>Relationship</u>		<u>Telephone</u>	
1.	_____		_____		(____) _____	
2.	_____		_____		(____) _____	
3.	_____		_____		(____) _____	
I understand that I have the right to revoke this authorization at any time by providing Associates in Cardiology, LLC with written notification. I also understand that any revocation shall be effective the date it is included in the medical record and will not be retroactive.						
Signature: _____			Date: _____			