

Augusta Heart Associates, P.A.

818 Saint Sebastian Way, Suite 308

Augusta, Georgia 30901

Telephone (706) 724-4400

Fax (706) 724-6003

Patient Registration

Patient Name: _____ S.S# _____
DOB: _____
Street Address: _____
City/State: _____ Zip _____ Sex: M F
Home Phone: _____
Emergency Contact: _____ Marital Status: S M W SEP D
Relationship: _____ Phone: _____
Referred By _____

Patient Employer Information

Employer's Name: _____ Work# _____
Patient's Occupation _____

Insured Person (If Not Patient)

Name of Insured Person: _____ S.S# _____
Work# _____
Employer: _____
DOB: _____
Relationship: _____

Insurance Information

Please Provide Insurance Cards and Identification for Verification

**Authorization to Release Information
And Assignment of Benefits**

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORIGINAL.

SIGNATURE _____ DATE _____

I HEREBY AUTHORIZE AUGUSTA HEART ASSOCIATES TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES PROVIDED. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRCTLY TO THIS PROVIDER.

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY.

SIGNATURE _____ DATE _____