Nipun Arora, M.D. FACC
Vikas Verma, M.D. FACC

ORLANDO CARDIAC & VASCULAR SPECIALISTS LLC

Rajesh Shah, M. D. FACC
Sambit Mondal, M.D. FACC

PATIENT REGISTRATION

Directions: *Please complete all sections, initial where necessary, and sign at the bottom. Write N/A if not applicable.*

Last Name:	First Name:		MI:	Date:
Sex: ☐ M ☐ F	DOB: __ /__ / ____	Age:	SSN:	Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced
Home Phone#:	Cell / Alternative Phone #:			Email:
Address (Street) :	City:		State:	Zip:
Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student	Employer Name:			Work Phone:
Primary Care/ Family Doctor Name:				
Doctor Office Phone #:				
May we call you at home and leave a message? ☐ YES ☐ NO (Please see the bottom of the page to authorize us to speak with others about your care.)				
How did you hear about us? ☐Family ☐ Friend ☐ Employer ☐ Doctor _____ ☐Other _____				

Insurance Information:

Primary Insurance Information:		Primary Insurance Information:	
Insurance Name:		Insurance Name:	
Phone Number:		Phone Number:	
Group Number:	ID/ Policy Number:	Group Number:	ID/ Policy Number:
Name of Policy Holder (if different from patient's name):		Name of Policy Holder (if different from patient's name):	
Policy Holder DOB: ____ / ____ / _____	Policy Holder's SSN (REQUIRED):	Policy Holder DOB: ____ / ____ / _____	Policy Holder's SSN (REQUIRED):

Emergency Contact Information:

Name:		Name:	
Phone Number:	Relationship to patient:	Phone Number:	Relationship to patient:

Contact Information for (family/friends) to discuss your medical care:

Name:	Phone #:	Relationship to Patient:
Name:	Phone #:	Relationship to Patient:
Name:	Phone #:	Relationship to Patient:

251 Maitland Ave., Suite 116, Altamonte Springs, FL 32701 ***Tel: 407.915.5643***
1301 South International Pkwy., Suite 1001, Lake Mary, FL 32746 ***Fax: 407.960.2602***

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MEDICATIONS AND ALLERGIES

Date: _____

Patient Name: _____ **DOB:** _____

Reason for today's visit: _____

_____

Medications

Preferred Pharmacy Name: _____

Location: _____ **Phone:** _____

Please list all current medications including Prescription, Non Prescription (ex. Aspirin), and Supplements you are taking:

Medication Name	Dosage	Frequency

Allergies

Please list all known allergies: _____

_____

_____

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PATIENT CONSENT

Consent for Treatment

I authorize Orlando Cardiac & Vascular Specialists LLC (OCVS) to examine me and order/perform such tests, procedures and/or treatment that are reasonable and necessary in the diagnosis and treatment of my case. I hereby acknowledge that I am seeking medical care on my volition without any coercion.

_____
Initial

Insurance Assignment & Patient/Guarantor Agreement

I authorize payment from any insurance company or any governmental agency to OCVS for any medical or surgical benefits otherwise payable to me for the services provided by OCVS, but not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for charges not paid by this assignment.

I further understand that it is my responsibility to understand the coverage my insurance policy provides including any out of pocket expenses I am responsible for as well as the referral and authorization process for services. If proper authorization is not obtained from my Primary Care Physician (PCP), I will be liable for charges incurred for those services.

I will assist in the collection of my insurance should there be any delay in payment. I agree to actively pursue collecting insurance payment for any claims unpaid after thirty (30) days. If after forty-five (45) days the claim remains unpaid, I understand the balance may be due from me.

_____
Initial

Patient Notification Responsibility

If my follow-up appointment for any study, test and/or procedure is cancelled or rescheduled by myself or by OCVS, I understand it is my responsibility to contact the office within 7–10 days after the study/test/procedure has been completed to verify results are negative/normal/stable and no other testing/office visit is necessary.

_____
Initial

Appointment Reminder

- OCVS may leave a message at my **home:** ☐Yes ☐No
- OCVS may leave a message at my **work** using doctor's/practice name: ☐Yes ☐No
- OCVS has permission to discuss my medical care with myself and the following:

_____

_____
Initial

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Medicare Patients Only

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize OCVS to release to the Health Care Financing Administration or its carriers or intermediaries any information needed for this or related Medical claims.

I hereby authorize payment directly to OCVS for medical benefits otherwise payable to me as a beneficiary of the Medicare Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as, but not limited to, routing testing may not be covered by Medicare unless the physician provides medical necessity.

_____
Initial

Original Assignments, Authorizations, and Releases on File

I permit a copy of the above assignments, authorizations, and releases to be used in place of the original, which has been filed in the office of Orlando Cardiac & Vascular Specialists LLC.

_____
Initial

Attestation: By signing below, I agree to all information stated herein and understand my rights and responsibilities as a patient of Orlando Cardiac & Vascular Specialists LLC.

_____ _____
Signature of Patient or Patient Representative Date

_____ _____
Printed Name of Patient or Patient Representative Relationship to Patient