St Luke's™
Idaho Cardiology Associates

PATIENT REGISTRATION
(Please Print - Press Firmly)

Dr. #
Acct. #

Name: _____ Date: _____
(First Name) (Middle Initial) (Last Name)

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

Street Address (if different): _____ City _____ State: _____ Zip: _____

Home Telephone Number: _____ Cell Phone Number: _____ D.O.B.: _____ SS#: _____

Employer: _____ Occupation: _____ Work Phone: _____

Please mark appropriate box: ❑ Single ❑ Minor Child ❑ Widowed ❑ Married ❑ Divorced Sex: M or F

Spouse's Name: _____ Social Security No.: _____

Spouse's Employer: _____ Occupation: _____ Work Phone: _____ Cell Phone: _____

Referring Physician: _____ Office Phone Number: _____

RESPONSIBLE PARTY - If patient is a Minor

Responsible Party's Name: _____ Social Security Number: _____

Relationship to Patient: _____ Home Phone: _____

Address and Phone if different:

Street: _____ City _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

HEALTH INSURANCE - Please give your card to the receptionist so that we may make a copy

❑ (✔ If address and phone is same as the patient's)

Primary Insurance Company: _____

Subscriber: _____ Identification # _____ Group No. _____ Effective Date _____

Secondary Insurance Company: _____

Subscriber: _____ Identification # _____ Group No. _____ Effective Date _____

Third Insurance Company: _____

Subscriber: _____ Identification # _____ Group No. _____ Effective Date _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT NOT CURRENTLY LIVING WITHIN YOUR HOUSEHOLD?

Name: _____ Relationship to Patient: _____ Phone: _____

Address: _____

All accounts are due and payable at the time of visit unless other arrangements are made at the time of appointment. I understand that I am responsible for any and all balance owing. I hereby authorize the Physician(s) of St. Luke's Idaho Cardiology Associates to release any information acquired in the course of my treatment to my insurance company. Additionally, I authorize any insurance payments to be made directly to the Physician(s) of St. Luke's Idaho Cardiology Associates for any and all medical and/or surgical services rendered.

Signature _____ **Date** _____

Date											
Initial											

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