Centennial Heart CARDIOVASCULAR CONSULTANTS

Welcome to Centennial Heart

Thank you for choosing Centennial Heart for your cardiology care. We want to ensure you have a pleasant visit.

To help us better serve you, we ask that you **arrive at least 30 minutes prior to your scheduled appointment** to allow time for parking, taking X-rays and sharing additional medical information, if needed.

Additionally, we strongly encourage you to **complete these new patient registration forms and bring them to your appointment, along with your**:

- Current insurance card(s)
- Driver's license or photo ID
- Current medications in the BOTTLE (not a listing)
- Name, address and phone numbers of your primary care physician and any other specialists you have recently seen

If your insurance requires a referral and/or authorization, please contact your PCP prior to your visit to obtain the referral and/or authorization. This can be faxed to our office at 615-292-4633. If the referral and/or authorization are not received prior to your appointment, you may be asked to reschedule.

Co-pays, deductibles and other out-of-pocket expenses should be paid at time of service. For your convenience, we accept cash, checks, Visa, MasterCard, and American Express.

Please feel free to contact our office at 615-515-1900 if you have questions, need additional information or have to reschedule your appointment.

Thank you for selecting our practice! We look forward to serving you!

Physicians and Staff of Centennial Heart

Phone: 615-515-1900 **Fax:** 615-292-4633 **Office Hours: Mon-Fri 7:30 am - 5 pm**

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PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number: _____ - _____- _____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM ____/DD ____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number: _____-_____-_____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient: _____ ☐ Guardian

Address _____

City, State: _____ ZIP: _____

Home phone: _____ Work hone: _____ Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: