COLLINS CARDIOLOGY

1208 Ocilla Rd., Douglas, GA 31533 T (912) 384-6276, F (912) 389-1618

Dr. Darrel Collins, DO Tara Spivey, PA

REGISTRATION FORM

Patient Information

Date: _____ Primary Physician: _____ Preferred Pharmacy: _____

Legal Name: (Last) _____ (First) _____ (Middle) _____

Date of Birth: _____ Age: _____ Gender: Male ☐ Female ☐

Race: Asian ☐ Black or African American ☐ Black Hispanic or Latino ☐ Native Hawaiian/Other Pacific-Islander ☐

White ☐ White Hispanic or Latino ☐ Refused ☐ Unknown ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Refused ☐

Mailing Address: _____ City: _____ State & Zip Code: _____

Street Address: _____ City: _____ State & Zip Code: _____

Social Security Number: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Occupation: _____ Full Time ☐ Part Time ☐ Employment: _____

Employer Address: _____ Phone: _____

Legal Guardian: _____ Phone: _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Name of Spouse: _____ Phone: _____

2nd Phone: _____ E-mail: _____

Insurance Information

Primary Insurance Plan: _____ Insurance ID: _____ Group No: _____

Primary Insurance Provider: _____

Secondary Insurance Plan: _____ Insurance ID: _____ Group No: _____

Secondary Insurance Provider: _____

Other:

Emergency Contact

Full Name: _____

Street Address: _____ City: _____ State & Zip Code: _____

Relationship To Patient: _____

Home Phone: Cell Phone: Work Phone:

Insurance Authorization and Payment Assignment

I hereby authorize this office to furnish any information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance. Furthermore, I agree to settle any unpaid bills or to make arrangements for prompt payment of the unpaid account. And, I agree that a copy of this authorization shall be valid as the original. I have read and understand the above terms and conditions.

Signature: _____ Date: _____

For Medicare Patient Only

Name of Beneficiary/Patient: _____

Medicare No.: _____

Authorization and Payment Assignment:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Darrel Collins for any services furnished me by that physician. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determine these benefits payable for related services. I have read and understand the above agreement.

Signature: _____ Date: _____