S. TARIQ SHAHAB, MD
THE HEART INSTITUTE
d/b/a VASCULAR AND INTERVENTIONAL CARDIOLOGY
6400 Arlington Blvd., Ste 930 Falls Church, VA 22042-2336

PATIENT REGISTRATION

DO YOU HAVE A LIVING WILL? YES___ NO___ INITIALS___

PATIENT NAME: M.I. LAST			MALE / FEMALE M______F______	SOCIAL SECURITY#	DATE OF BIRTH
HOME ADDRESS	CITY	STATE	ZIP	PHONE # 1 ___home ___cell ___work	
EMPLOYER ADDRESS	E-mail address			PHONE #2 ___home ___cell ___work	
OCCUPATION	ALLERGIES TO MEDICATIONS			MARITAL STATUS __S___M___W___D	
PRIMARY DOCTOR: FIRST and LAST NAME (Give address and phone if known)					
SPOUSES NAME	Contact Number				
PERSON TO CONTACT IN CASE OF EMERGENCY (NOT RESIDING WITH YOU)				TELEPHONE	
POLICY HOLDER NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH		FINANCIALLY RESPONSIBLE PERSON ____PATIENT_____SPOUSE PARENT OTHER	
EMPLOYER					

Primary Insurance Billing Information		Secondary Insurance Billing Information	
Ins. Co. Name		Ins. Co. Name	
Address:		Address:	
City, State & Zip:		City, State & Zip:	
ID. No:		ID. No:	
Group Name:	Group #:	Group Name:	Group#
Subscriber:	Subscriber Date of Birth:	Subscriber:	Subscriber's Date of Birth:
Subscriber's Social Security #		Subscriber's Social Security#	

PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with out office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize S. Tariq Shahab, M.D. to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

Date

Signature of Subscriber or Beneficiary

I acknowledge that I have been offered a copy of the privacy notice of S. Tariq Shahab, M.D.

Copy Taken______Copy Decline______

Date

Signature of Patient