HeartCARE
CENTER OF THE VALLEY

Heart Care Center of the Valley 2680
S Val Vista Dr, Bldg. 16, Ste 187
Gilbert, AZ 85295
(480) 476-8750

REGISTRATION FORM

Today's date:	Referred By:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Primary phone no: ( )	Other phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Email address:	Primary Care Physician and phone number:

INSURANCE INFORMATION

(Please give your insurance card(s) and ID to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Primary phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's id. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Legal Guardian	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Legal Guardian	❑ Other

AUTHORIZED INDIVIDUALS TO WHOM MEDICAL INFORMATION MAY BE RELEASED

Name:	Relationship to patient:	Birth date:	Primary phone no.: ( )
Name:	Relationship to patient:	Birth date:	Primary phone no.: ( )

PHARMACY INFORMATION

Pharmacy:	Address:

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IN CASE OF EMERGENCY

Name:	Relationship to patient:	Primary phone no.: ( )	Other phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Mohammad Reza Hojjati MD PHD PLLC. I understand that I am financially responsible for any balance. I also authorize Mohammad Reza Hojjati MD PHD PLLC or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

AUTHORIZATION TO VIEW AND OBTAIN EXTERNAL PRISCRIPTION HISTORY

I authorize the medical providers of Mohammad Reza Hojjati MD PHD PLLC to view and obtain my external prescription history via electronic prescription services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff through these services, and may include prescriptions back in time for several years.

Patient/Guardian signature *Date*

NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Mohammad Reza Hojjati MD PHD PLLC. The Notice of Privacy Practices also describes my rights and Mohammad Reza Hojjati MD PHD PLLC's duties with respect to my protected health information. The Notice of Privacy Practices can also be found on the Mohammad Reza Hojjati MD, PhD PLLC website at heartcareaz.com.

Mohammad Reza Hojjati MD PHD PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the heartcareaz.com website.

Patient/Guardian signature *Date*