



## Khalid Shafiq, M.D., F.A.C.C.

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Diplomate American Board of Internal Medicine and Cardiovascular Disease  
Diagnostic & Interventional Cardiology

### PATIENT REGISTRATION

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_  
Dr. Lic. # \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Sex ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_  
Referring Physician \_\_\_\_\_  
Next of Kin Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

### PRIMARY INSURANCE

Person Responsible for Account (Last Name) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Responsible Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

### ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insured Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. \_\_\_\_\_ all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.

I Authorize the above noted doctor and/or any provider or supplier of services in this office to release any information requested to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_