JOHNSTOWN HEART & VASCULAR CENTER

Samir Hadeed, MD, FACC, FSCAI.

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____

Male ____ Female ____ Date of Birth: _____ Marital Status: S M D W (circle one)

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Mobile Phone: _____ Social Security #: _____

Pharmacy Name: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____Phone: _____

Place of Employment: _____ Phone: _____

Insurance Referral Presented if Necessary: _____ Co-pay: _____

Email Address: _____@_____

Nearest Relative or Person we may contact in case of an emergency
(Outside of your home)

Name: _____Relationship: _____

Address: _____Telephone #:_____

Assignment of Benefits Authorization for Treatment:
I hereby authorize treatment and authorize direct payment of surgical/medical benefits to Johnstown Heart & Vascular Center for services rendered by Dr. Samir Hadeed, in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized benefits be made on my behalf.

Print Patient Name: _____

Signature: _____Date: _____