CARDIOVASCULAR CONSULTANTS
Lawrence Lieberman, M.D.

PATIENT REGISTRATION FORM

Today's Date:_______________________

Name:____ Sex: ___M ___F

Local Address: ____

____

City: _________________________ State:___________ Zip:____________

Home Phone:______________________ Work Phone:______________________

Date of Birth: ____________________ Age:______ SS#: ________________

Employer: ________________________ Job Title:________________________

Family MD:_______________________ Referring MD: ____________________

Out of State Address: ____

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Out of State Phone #: (______) ___________

Insurance Card: Please present to receptionist to photocopy for file . __________
(check if completed)

Reason for Visit: ____

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I hereby authorize Dr. Lieberman to release all or part of my medical records to medicare and/or any other companies, if requested, without any liability to Dr. Lieberman. I hereby authorize Medicare and/or my insurance companies to pay directly to Pinnacle Cardiovascular Consultants any payments, assignments or benefits due me.

____ Date: __________
Patient Signature

CL A