Twin Hearts, LLC
2900 N Military Trail, Suite 150, Boca Raton, FL 33431
801 Meadows Rd, Suite 105, Boca Raton, FL 33486

PATIENT INFORMATION

Patient Number:	Gender:	Date of Birth:	
Last Name:		Age:	Marital Status:
First Name:	Initial:	Social Security #:	
Address:		Home Phone:	
City, State, Zip:		Work Phone:	
Email Address:		Cell Phone:	
Employer:			

RESPONSIBLE PARTY

Account #:	Patient Relationship to Guarantor:
Last Name:	Gender:
First Name:	Date of Birth:
Address:	Home Phone:
City, State, Zip:	Work Phone:
Employer:	Cell Phone:

INSURANCE INFORMATION

Primary Insurance:	Policy/Subscriber:
Address:	Date of Birth:
City, State, Zip:	Insured Policy ID:
Plan Phone:	Group Number:
Effective Dates:	Patient Relationship to Subscriber:
Secondary Insurance:	Policy/Subscriber:
Address:	Date of Birth:
City, State, Zip:	Insured Policy ID:
Plan Phone:	Group Number:
Effective Dates:	Patient Relationship to Subscriber:

MISCELLANEOUS INFORMATION	EMERGENCY CONTACT INFORMATION
What is the best telephone number to contact you?	Emergency Contact: Patient relationship to Contact:
I authorize Tanveer A. Sheikh, M.D./Andrea McGlone, PA-C to leave a message containing detailed medical information at the number listed above.	Contact Home Phone: Contact Work Phone: Contact Cell Phone:
Signature:	

Acct #: Patient Name: Date of Birth:

What is your preferred Pharmacy:	Who referred you to us? Please circle one:
Name:	Friend Relative Physician Existing Patient
Phone: ( ) ________-__________	Insurance Other (Please specify)
Location:	____

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

INSURANCE AUTHORIZATION AND ASSIGNMENT. I hereby authorize Twin Hearts, LLC to furnish information to my Insurance Carrier concerning illness and treatments and hereby assign Twin Hearts, LLC. payments for medical services rendered to myself or dependents. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.**

Signature x____ **Date:** ________________

Notice of Privacy Acknowledgement

- I acknowledge that the Notice of Privacy Practices is available.
  (If you would like a copy of the Privacy Practices, please request one at the front desk)
- I acknowledge that due to the current HIPPA laws my doctor is required to obtain a written consent to disclose any Private Health Information in the presence of anyone other than myself.

Please check the corresponding line:

_____ **I ALLOW** Tanveer A. Sheikh, M.D./Andrea McGlone, PA-C to discuss details of my medical records/financial records with ______________________________
(Please print name of authorized family member or friend)

Relation (of authorized person) to patient ______________________________________

_____ **I DO NOT ALLOW** Tanveer A Sheikh MD/Andrea McGlone, PA-C to discuss details of my medical records/financial records with anyone else but me.

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS I AM RESPONSIBLE FOR ANY AND ALL BALANCES ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HEREBY ASSIGN ALL MEDICAL/SURGICAL INSURANCE PAYMENTS TO TWIN HEARTS, LLC.

____
Patient's Signature Patient's Name

____
Date