NORTH ATLANTA CARDIOLOGY PC

2870 Ronald Reagan Blvd
Suite 200
Cumming, GA 30041

MICKY MISHRA, MD FACC

Phone: 404-994-4561
Fax: 404-994-4562

REGISTRATION INFORMATION

Name: _____ **Date of Birth:** _____

Address: _____ **Social Security No:** _____

_____

Phone Number (Cell): _____ **Home:** _____

EMAIL (Used only to allow patient login To Patient Portal): _____

Employment:

____Employed ____ Retired ____ Unemployed ____Married ____Single ____Divorced ____Life Partner

Employer: _____ Phone: _____

Circle one or fill in:

Primary Language: English – Spanish – Other _____

Ethnicity: Hispanic – Not Hispanic - Decline

Race: Caucasian – African American – Hispanic – Asian – Native Hawaiian or Other Pasific Islander – American Indian or Alaska Native - Other: _____

Emergency Contact Name: _____ **Relation:** _____

Emergency Contact Phone: _____

Primary Care Physician Name: _____ **Phone:** _____

Location Address: _____**Fax:** _____

Referring Physician: Name: _____ **Phone:** _____

Location Address_____ **Fax:** _____

Insurance Information:

Insurance Company: _____ Effective Date: _____

Name of Policy Holder: _____Policy Holder DOB: _____

Relation to Policy Holder: _____Policy Holder Employer Name: _____

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Secondary Insurance Company (if applicable): _____Effective Date: _____

Name of Policy Holder: _____Policy Holder DOB: _____

Relation to Policy Holder: _____Policy Holder Employer Name: _____

Pharmacy Information: As part of the Electronic Medical Record North Atlanta Cardiology uses the Surescripts Network to fill prescriptions electronically (e-prescribe).

Pharmacy Name: _____ Phone: _____

Location Address: _____

I consent to have messages regarding test results and appointment reminders left on a voicemail: (Initial)
_____Voicemail/Home #:_____
_____Voicemail/Cell #:_____

I do not consent to have messages regarding my test results or appointment reminders on any voicemail_____(Initial)

Do you have an Advanced Directive? (for informational purpose only)
____ Yes _____ No If yes, please provide a copy for your health record.
Check all that apply: _____ Living Will _____ Power of Attorney

Assignment of Benefits/Consent for Treatment:
I hereby assign all medical and/or surgical or testing benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance and understand all referrals are my responsibility. I authorize this office to release all information necessary to secure payment. I voluntarily give consent for my medical treatment or my dependent's medical treatment to North Atlanta Cardiology, P.C. and authorize such treatment, examination, medications and diagnostic procedures including the use of radiographic studies, and lab, as ordered by my physician.

_____ _____
Patient Signature Date