Jeffrey S. Fenster, M.D., F.A.C.C.
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Jupiter, Florida 33477

Cardiac Institute
OF THE PALM BEACHES, PA

PINNACLE Registry

Phone: 561-296-5225 Fax: 561-296-5226

Date: _____ Referred by: _____

Pharmacy Name: _____ Location: _____Phone: _____

Name: _____

(Last) (Middle Initial) (First)

Address: _____

(Local Address Please)

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number_____

Second Address: _____

City: _____ State: _____ Zip: _____

Alternate phone number for second address: _____

E-Mail Address: _____

Emergency Contact: _____

(Name) (Phone)

Do you have an advanced care plan (Living will, power of attorney, etc?) _____

If our office is not contracted with your insurance plan, you will be considered out of network. Claims will be submitted to your insurance company on your behalf. However, charges for all services rendered are ultimately the responsibility of the patient (both in-network and out of network). Your signature below is a consent for medical treatment, consent to bill your insurance, consent to provide any information required to process the claims and acknowledgment that any charges unpaid by your insurance are your responsibility.

Signature:_____ Date:_____