CARDIOVASCULAR CONSULTANTS, LTD.

Registration

Name: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell/Pager Phone: (_____) _____ **Email Address:** _____

Date of Birth: _____ Sex: M F SSN: _____ Preferred Language: _____

Race:
[ ] American Indian/Alaskan Native
[ ] Asian
[ ] Black /African American
[ ] Native Hawaiian / Pacific Islander
[ ] White
[ ] Other
[ ] More than one race
[ ] Decline to Report or unavailable

Ethnicity:
[ ] Hispanic or Latino
[ ] Not Hispanic or Latino
[ ] Decline to report or unavailable

Marital Status:
[ ] Married [ ] Single
[ ] Divorced [ ] Widow

How did you hear about us?
[ ] Relative/Friend
[ ] Internet
[ ] Doctor
[ ] Other

Employer: _____ Work Phone: (_____) _____

Primary Care Physician: Full Name: _____

Referring Physician: Full Name: _____

SPOUSE'S INFORMATION

Spouse's Name: _____
Last First Mi

Address: _____
If different from above address

Spouse's SSN: _____ DOB: _____ Contact Phone: (_____) _____

INSURANCE INFORMATION

Primary Insurance Company: _____

ID #: _____ Group #: _____

Name of Person Insured: _____ Phone #: (_____) _____

Policy Holder's Birthdate: _____ Social Security #: _____

Address to Mail Claims: _____ City/State: _____ Zip: _____

Secondary Insurance Company: _____

ID #: _____ Group #: _____

Name of Person Insured: _____ Phone #: (_____) _____

Policy Holder's Birthdate: _____ Social Security #: _____

Address to Mail Claims: _____ City/State: _____ Zip: _____

Emergency Contact: _____

Address: _____ City/State: _____ Zip: _____

Relationship to Patient: _____ Phone: (_____) _____

I hereby assign my insurance benefits to be paid to Cardiovascular Consultants, Ltd. I understand that I am financially responsible for this bill regardless of insurance coverage. I also authorize the release of any information required in the processing of insurance claims. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required). I have been given a copy of the Patient Financial Responsibilities Form.

Patient Signature: _____ **Date:** _____