



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: | Ethnicity: | How did you hear about us? |
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Relative/Friend |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Decline to report or unavailable | <input type="checkbox"/> Doctor |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander | | <input type="checkbox"/> Other |
| <input type="checkbox"/> White | Marital Status: | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Married <input type="checkbox"/> Single | |
| <input type="checkbox"/> More than one race | <input type="checkbox"/> Divorced <input type="checkbox"/> Widow | |
| <input type="checkbox"/> Decline to Report or unavailable | | |

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:** _____