Cardiovascular Specialists of Frederick, LLC
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PATIENT REGISTRATION

PLEASE PRINT CLEARLY

PATIENT NAME First - Middle Initial - Last	Please check one: Male ☐ Female ☐	DATE OF BIRTH	AGE	PATIENT SOCIAL SECURITY NUMBER
Street Address		City	State	Zip Code
Email Address	Home Phone	Work Phone	Cell Phone	
Patient's Employer	Employment Address		Occupation	
Emergency Contact		Relationship to patient	Emergency contact Phone #	
Financially Responsible Person's Name First - Middle Initial - Last		Responsible person's address	Phone number	

Race	Ethnicity	Language	Name of Primary Care Physician	PCP Phone number

Insurance Information

Primary Insurance Company name and address		Policy Holder (Check One) ☐ Self ☐ Spouse ☐ Parent	Policy Number	Group Number
Policy Holder's Name	Policy Holder's SSN	Policy Holder's DOB	Group Name (Employer)	

Secondary Insurance Company Name and address		Policy Holder (Check One) ☐ Self ☐ Spouse ☐ Parent	Policy Number	Group Number
Policy Holder's Name	Policy Holder's SSN	Policy Holder's DOB	Group Name (Employer)	

PATIENT'S AUTHORIZATION

I, _____, hereby authorize Cardiovascular Specialists of Frederick, LLC to release any necessary information, including medical information that may be necessary to request claim reimbursement to any company to whom claims have been submitted. I permit a copy of this form, my insurance authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

I certify that the information I have reported regarding my insurance coverage is correct. I also assign the claim payment to be made payable to Cardiovascular Specialists of Frederick, LLC.

I understand that if any unpaid balance necessitates legal action (attorney and/or court fees) to collect this balance, I will be responsible for all attorney and/or court costs.

Signature of Patient or Authorized Person_____ Date _____