

PATIENT REGISTRATION
 PLEASE PRINT CLEARLY

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|--|-----------|----------|-----------------------------------|--|------------------------------|-----|--------------------------------|--------------|
| PATIENT NAME First M.I. Last | | | Please circle 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 M.I. Last | | | | | Responsible person's address | | | Phone number |
| Race | Ethnicity | Language | Name of Primary Care Physician | | | | PCP Phone number | |

Insurance Information

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|--|--|---------------------|---|--|-----------------------|--------------|
| Primary Insurance Company name and address | | | Policy holder (Circle 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 (Circle 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 if my account becomes assigned to a collection agency, I agree to pay collection agency fees of 22%, court costs, and attorney fees. Allowed by Law interest can accrue in the amount of 18%.

Signature of Patient or Authorized Person _____ Date _____