Cardiovascular Specialists of New England

PATIENT REGISTRATION (Please complete and print)

PATIENT INFORMATION

FULL NAME_____ DATE OF BIRTH____/____/____ AGE ____

LOCAL ADDRESS_____ APT/SP_____ ☐ Male ☐ Female Marital Status ☐ S ☐ M ☐ W ☐ D Spouse_____

CITY_____ STATE_____ ZIP CODE_____ HOME PHONE _____

SUMMER VISITOR Yes ☐ No ☐ PERMANENT ADDRESS _____ APT/SP_____

CITY_____ STATE_____ ZIP CODE_____ HOME PHONE_____ CELL PHONE_____

WORK PHONE _____ DRIVER'S LICENSE NO._____ STATE

EMPLOYER_____ ADDRESS_____ BUSINESS PHONE_____

If retired, please state company_____

EMERGENCY CONTACT_____ RELATIONSHIP_____

STREET_____ CITY_____ STATE_____ ZIP_____ PHONE_____

REFERRED BY_____
NAME PHONE

EMAIL ADDRESS_____

RACE:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ More than one Race
☐ Other Race
☐ White

ETHNICITY:
☐ Hispanic or Latino
☐ Non Hispanic or Latino
☐ Unknown/Not Reported

EMERGENCY CONTACT

Preferred Language_____

FULL NAME_____ RELATIONSHIP_____ SOCIAL SECURITY NO. _____

ADDRESS_____ DATE OF BIRTH____/____/____

CITY_____ STATE_____ ZIP CODE_____ HOME PHONE_____

EMPLOYER_____ BUSINESS TELEPHONE _____

ADDRESS_____ ZIP CODE_____

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER_____ HMO OR PPO? YES ☐ NO ☐ CO PAYMENT? $_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

GROUP NO._____ ID OR POLICY NO._____

NAME OF POLICY HOLDER_____ RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE CARRIER_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

GROUP NO._____ ID OR POLICY NO._____

NAME OF POLICY HOLDER_____ RELATIONSHIP TO PATIENT_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS & PAYMENT OF ACCOUNT

I authorize Cardiovascular Specialists of New England to release medical information for insurance purposes concerning treatment of the above patient while under their care. I assign my rights to benefits of insurance plans to Cardiovascular Specialists of New England, and I agree to pay any fees not covered by insurance. If collections proceedings are required, I agree to pay reasonable collection fees. I also authorize my hospital records be released to Cardiovascular Specialists of New England.

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SIGNATURE DATE