

Account#: _____

CARDIOVASCULAR SPECIALISTS, P.C.
5669 PEACHTREE DUNWOODY ROAD-SUITE 170-ATLANTA, GEORGIA 30342

Date: _____ Referring/Primary Physician: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: ____/____/____ Age: _____ Sex: M F

Marital Status: S M W D SS#: _____ Employed: Yes No

Employer/School: _____

Home Phone#: _____ Cell Phone#: _____

Work Phone#: _____ Ext: _____

Spouse Name: _____ Date of Birth: ____/____/____

Pharmacy/City: _____ Pharmacy Phone#: _____

INSURANCE

Primary Insurance: _____ Secondary: _____

Policy Holder: _____ Policy Holder: _____

Policy ID#: _____ Policy ID#: _____

INSURANCE CARDS MUST BE PRESENT AT THE TIME OF REGISTRATION

EMERGENCY CONTACT

Name: _____ Phone#: _____

Relationship: _____

I hereby certify that the above information is correct and authorize Cardiovascular Specialists, P.C. to release information to my insurance company for the purpose of processing insurance claims. I also agree to pay any and all charges that exceed my benefit level as well as non-covered services. I hereby authorize my insurance company to make payment of medical benefits directly to Cardiovascular Specialists, P.C. I understand Physician Assistants are utilized at Cardiovascular Specialists, P.C. and may provide care for me during my office visit.

Patient Signature: _____ Date: _____