Cardiology Specialists of Virginia, P.C.

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PATIENT REGISTRATION New Patient ***Please Print Clearly.*** ***Please include AREA CODE for all phones.***
PLEASE COMPLETE ALL INFORMATION. DO NOT LEAVE BLANKS. USE "NONE" OR "N/A" AS NEEDED.

PATIENT NAME First	Middle	Last		HOME PHONE	CELL PHONE
HOME ADDRESS	APT. NO.	CITY	STATE		ZIP
EMPLOYER	ADDRESS			WORK PHONE	
OCCUPATION	SOCIAL SECURITY NO.	MARITAL STATUS (circle) S M D W	DATE OF BIRTH	AGE	SEX (circle) M F
FINANCIALLY RESPONSIBLE PERSON (circle) Patient Spouse Parent Other	NAME (IF NOT PATIENT)	HOME PHONE	CELL PHONE	WORK PHONE	
SPOUSE'S NAME					
SPOUSE'S EMPLOYER				WORK PHONE	
ALLERGIES					
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP		BEST PHONE(S)	
REFERRED BY	ADDRESS				PHONE
FAMILY PHYSICIAN	ADDRESS				PHONE
PRIMARY INSURANCE CO	POLICY HOLDER NAME		POLICYHOLDER DOB	RELATIONSHIP TO PATIENT	
ID CONTRACT NO.	GROUP NO.		CODE #	PHONE #	
PRIMARY INSURANCE CO. ADDRESS (Street/Box, City, State, ZIP)					
SECONDARY INSURANCE COMPANY	POLICY HOLDER NAME		POLICY HOLDER DOB	RELATIONSHIP TO PATIENT	
SECONDARY ID CONTRACT NO.	SECONDARY GROUP NO.		CODE #	SECONDARY PHONE #.	
SECONDARY INSURANCE ADDRESS (Street/Box, City, State, ZIP)					
WORKERS COMPENSATION (INJURED ON JOB)	Are you claiming Workers Compensation?		Yes	No	
DATE OF ACCIDENT	CLAIM/FILE #	INSURANCE CARRIER			
INSURANCE CARRIER'S ADDRESS (Stree	t/Box #, City, State, ZIP)			EMPLOYER	
NOTIFIED? Yes No					

NOTE – IN ALL CASES, BILLS ARE THE PATIENT'S RESPONSIBILITY

PATIENT'S AUTHORIZATION

I, _____, hereby authorize Cardiology Specialists of Virginia, PC to apply for benefits on my behalf for covered services rendered by Cardiology Specialists of Virginia, PC, and request that payments from Blue Cross and Blue Shield of the National Capital Area/Medicare and/or _____ be made directly to Cardiology Specialists of Virginia, PC (or in case of Medicare part B benefits, to myself or to the party who accepts assignment).

I certify that the information that I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, Blue Cross and blue Shield of The National Capital Area (or in case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration), Medicare and/or _____. I permit a copy of this authorization to be used in place of the original. Either the above named carrier or I may revoke this authorization at any time in writing.

Acct #_____ Signature of Subscriber_____ Date_____