



Patient Registration

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Mailing Address: _____ Soc. Sec #: _____

City: _____ State: _____ Zip: _____ Male Female Age: _____

Home Phone: _____ Work Phone: _____ Marital Status: M S D W

Cell Phone: _____ Email Address: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

Referred By: Primary Care Physician (Full Name Of Doctor): _____

Address: _____ Phone #: _____

Primary Insurance Company

Policy Holder: _____ Relationship To Patient: _____

SSN# of Policy Holder: _____ Date of Birth: _____

Name of Primary Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Policy Id #: _____ Group #: _____

Secondary / Supplemental Insurance Company

Policy Holder: _____ Relationship To Patient: _____

SSN# of Policy Holder: _____ Date of Birth: _____

Name of Secondary Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Policy Id #: _____ Group #: _____

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I hereby authorize direct payment of medical/surgical benefits to Virginia Cardiovascular Associates, Manassas Heart Center and Warrenton Heart Center for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize Virginia Cardiovascular Associates, PC to release any medical or incidental information that may be necessary for either medical care or financial benefits. I request that payment of authorized benefits be made on my behalf.

I certify that the above information given by me in applying for payment is correct. A photo copy of these assignments shall be valid as the original. Should any of this information change, I am responsible for notifying this office in a timely fashion.

I understand that I am responsible for any collection fees associated with balances on my account.

I agree that I am fully responsible for payment for all services rendered to me. If my account is referred for collection I will pay, in addition to the original amount owed, all costs of collection including attorney's fees equal to 1/3 of the debt owed.

Signature: _____ Date: _____