CHICAGO
HEART & VASCULAR
SPECIALISTS

Patient Registration Form

PATIENT DEMOGRAPHICS			
Last Name	**First Name**	**Middle Initial**	
Address		**Date of Birth**	
City	**State**	**Zip Code**	**Sex** ☐ Male ☐ Female ☐ Other
Home Phone	**Cell Phone**	**Work Phone**	
Social Security Number	**Email Address**		
Marital Status ☐ Single ☐ Married ☐ Other			
Race/Ethnicity ☐ Caucasian (White) ☐ Black/African American ☐ Asian/Pacific Islander ☐ Hispanic/Latino ☐ Native American/Alaskan native ☐ Other			
Preferred Method of Contact: ☐ Email ☐ Phone ☐ Text message (Mark all that apply)			

RESPONSIBLE PARTY	
AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY	
Responsible Party Signature **X** ______________________	**Today's Date**

PRIMARY CARE PHYSICIAN	
Name	
Address	**Telephone**
	Fax

EMERGENCY CONTACT		
Name	**Relationship**	**Phone number**

PAYMENT OF BENEFITS	MEDICAL RELEASE OF AUTHORIZATION
I authorize payments of benefits, as determined by the Company, directly to the physician ☐ Yes ☐ No	Insured Party must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance

I understand that unless I have checked Yes above, I may still be responsible for any amounts not paid by my Insurance Company in the event that the charges made are not reasonable and customary.		company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.	
Signature X__________________________	Date	Signature X___________________________	Date