ADVANCED CARDIOVASCULAR CENTER

PATIENT REGISTRATION FORM

Patient Information

Last Name:..... First Name: ..... MI:.....

Street Address: ..... City: ..... ST:..... ZIP:.....

Home Phone:..... Cell Phone:..... Work Phone:.....

Date of Birth:..... Gender: ☐ Male ☐ Female SSN:..... Account#:.....

Email Address:.....

Race:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ White
- ☐ Other
- ☐ More than one race
- ☐ Decline to Report / Unavailable

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Report / Not Available

Marital Status:

- ☐ Married ☐ Single
- ☐ Divorced ☐ Widow

How did you hear about us?

- ☐ Relative / Friend
- ☐ Internet
- ☐ Doctor
- ☐ Other

Employer:..... Occupation:..... Work Phone:.....

Primary Care Physician Name:..... Phone:.....

Address:.....

Referring Physician Name:..... Phone:.....

Address:.....

Spouse Information

Last Name:..... First Name: ..... MI:.....

Street Address: .....

City: ..... ST:..... ZIP:.....

Date of Birth:..... SSN:..... Contact Phone:.....

13481 W McDowell Road, Suite 400, Goodyear, AZ 85395
Ph: 623-335-3044, Fax: 623-335-3054

23390 W Yuma Rd, Ste 100, Buckeye, Arizona 85326
Ph: 623-335-3044, Fax: 623-335-3054

Insurance Information

Primary Insurance Company:.....

ID:..... Group #:.....

Street Address:.....

City:..... ST:..... ZIP:.....

Name of Insured (Policy Holder):.....

Policy Holder Phone:..... Policy Holder Date of Birth:.....

Policy Holder SSN:.....

Secondary Insurance Company:

Primary Insurance Company:.....

ID:..... Group #:.....

Street Address:.....

City:..... ST:..... ZIP:.....

Name of Insured (Policy Holder):.....

Policy Holder Phone:..... Policy Holder Date of Birth:.....

Policy Holder SSN:.....

Emergency Contact

Last Name:..... First Name:.....

Relation to Patient:.....

Street Address:.....

City:..... ST:..... ZIP:.....

Home Phone:..... Cell Phone: ..... Work Phone:.....

I hereby assign my insurance benefits to be paid to Advanced Cardiovascular Center I understand that I am financially responsible for this bill regardless of insurance coverage. I also authorize the release of any information required in the processing of insurance claims. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required). I have been given a copy of the Patient Financial Responsibilities Form.

Date:

Signature: