Tacoma (253) 572-7320
Puyallup (253) 841-4347
Lakewood (253) 588-7778
Gig Harbor (253) 851-0404


# Patient Registration

CSC Account # ______________

| Last Name | First | Middle Initial | |
|---|---|---|---|
| Address | City | State | Zip Code |
| Primary Phone ( ) | Secondary Phone ( ) | Spouse's Name | |
| Patient's Gender M ☐ F ☐ | Date of Birth / / | Patient Social Security # | Marital Status Married ☐ Single ☐ Widower ☐ Divorced ☐ |
| Patient's Employer | Employer Phone # | Occupation | |
| Referred to Cardiac Study Center by Last First | Phone Number | | |
| Family Doctor Last First | Phone Number | | |

## Insurance Information

| Primary Insurance Company | Patient Is Subscriber ☐ Spouse ☐ Dependent ☐ | |
|---|---|---|
| Subscriber ID # | Group # | |
| Insurance Address | | |
| Subscriber Name and Address if Different From Patient | | |
| Subscriber's Social Security # | Subscriber's Employer | Subscriber's Date of Birth |

| Secondary Insurance Company | Patient Is Subscriber ☐ Spouse ☐ Dependent ☐ | |
|---|---|---|
| Subscriber ID # | Group # | |
| Insurance Address | | |
| Subscriber Name and Address if Different From Patient | | |
| Subscriber's Social Security # | Subscriber's Employer | Subscriber's Date of Birth |

## In Case of Emergency, Please Notify: (Friend or Relative not living with you)

| Name | Phone | Relationship |
|---|---|---|
| | | |

I request that payment of authorized medicare benefits and/or other insurance benefits be made either to me or on my behalf to the physician for any services furnished to me by that physician. I shall be personally responsible for any unpaid balance to the doctor. I authorize any holder of medical information about me concerning my examination, and/or treatment to release or submit electronically to the centers for Medicare and Medicaid services, its agents and/or my insurance carrier(s) any information needed to determine these benefits of the benefits payable for related services.

Patient Signature ______________________ Date __________