



Tacoma (253) 572-7320
Puyallup (253) 841-4347
Lakewood (253) 588-7778
Gig Harbor (253) 851-0404
Covington (253) 630-3300

Patient Registration CSC Account # _____

Last Name		First		Middle	
Address			City	State	Zip Code
Home Phone ()		Work Phone ()		Spouse's Name	
Patient's Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth / /	Patient Social Security #		Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/> Widower <input type="checkbox"/> Divorced <input type="checkbox"/>	
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 <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>			
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 <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>			
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
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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