CARDIO-
THORACIC
SURGEONS, P.C.

Patient Registration Form

PATIENT INFORMATION

Full Legal Name (First, Middle, Last, Suffix) **Nickname:** **Sex:** ☐Male ☐Female

Date of Birth **Social Security Number** **Race** **Preferred Language**

Ethnicity: ☐Hispanic ☐Non-Hispanic **Marital Status:** ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Life Partner

Complete Mailing Address (Street, City, State, Zip Code, County)

Home Phone Number: **Cell Phone Number:** **Work Number:**

Email:

Employment Status: ☐Full-time ☐Part-time ☐Active Duty ☐Self-employed ☐Not employed ☐Retirement Date:

Employer Name: **Employer Phone Number:**

Employer Complete Address (Street Address, City, State, Zip Code)

SPOUSE OR GUARANTOR INFORMATION (Responsible Party) ☐ Same as Patient

Full Legal Name (First, Middle, Last, Suffix) **Date of Birth** **Social Security Number**

Relation to Patient: ☐ Self ☐ Spouse ☐Mother ☐Father ☐Legal Guardian ☐Other: **Sex:** ☐Male ☐Female

Home Phone Number: **Cell Phone Number:** **Work Number:**

Complete Mailing Address – If Different From Patient (Street, City, State, Zip Code, County)

Employment Status: ☐Full-time ☐Part-time ☐Active Duty ☐Self-employed ☐Not employed ☐Retirement Date:

Employer Name: **Employer Phone Number:**

Employer Complete Address (Street Address, City, State, Zip Code)

EMERGENCY CONTACT INFORMATION

Name (First, Last):

Relation to Patient: ☐ Spouse ☐Mother ☐Father ☐Legal Guardian ☐Other:

Home Phone Number: **Cell Phone Number:** **Work Number:**

Complete Mailing Address – If Different From Patient

INSURANCE INFORMATION ☐**Self-pay (no insurance)**

Primary Insurance: **Patient relation to subscriber:** ☐Self ☐Spouse ☐Child ☐Other:

Secondary Insurance: **Patient relation to subscriber:** ☐Self ☐Spouse ☐Child ☐Other:

Prescription/Rx Provider: **(if different from insurance carrier)**

Full Name of subscriber: **(complete below if different from patient, spouse, or guarantor)**

Employment Status: ☐Full-time ☐Part-time ☐Active Duty ☐Self-employed ☐Not employed ☐Retirement Date:

Employer Name: **Employer Size:** ☐ 0-19 employees ☐ 20-99 ☐ 100+

Employer Complete Address (Street Address, City, State, Zip Code)

Primary Care Physician:	**Do you want anyone to know you are here? ☐Yes or ☐ No**