NORTH CASCADE
CARDIOLOGY
Providing excellence in cardiovascular care

PATIENT REGISTRATION FORM

Patient's Full Name ______________________________ Cell # ____-____-____

Street Address ______________________________ Apt# ________

City ______________ State ________ Zip ________ Home Phone ____-____-____

Patient's Social Security Number ____-____-____ Sex ______ Birthdate ____/____/____

Marital Status ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Employer ______________________________ Work Phone ____-____-____

Street Address ______________________________

City ______________________________ State ________ Zip ________

Name of Primary Insurance Company ______________________________

Subscribers Name ______________________________ Birthdate ____/____/____

Do you have a Co-Pay? YES / NO ______________ Amount of Co-Pay ______________

Name of Secondary Insurance Company ______________________________

Subscriber's Name ______________________________ Birthdate ____/____/____

Do you have a Co-Pay? YES / NO ______________ Amount of Co-Pay ______________

Spouse ______________________________

Spouse Social Security Number ____-____-____ Birthdate ____/____/____

Employer ______________________________ Work Phone ____-____-____

Street Address ______________________________

City ______________________________ State ________ Zip ________

I certify that the above information is correct to the best of my knowledge. I further assign directly to North Cascade Cardiology all medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature ______________________________ Date ____/____/____