



CARDIOLOGY ASSOCIATES OF NEW HAVEN - (203) 789-2272

Patient Registration

Patient Information	Last name _____ First Name _____ Initial _____
	Address _____ City _____ State _____ Zip _____
	Phone _____ Date of Birth _____ SS# _____ E-mail address _____
	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No Civil Union? <input type="checkbox"/> Yes <input type="checkbox"/> No Sex <input type="checkbox"/> M <input type="checkbox"/> F Name of Spouse/Partner _____
	<u>Person to Notify in Case of Emergency</u>
Name _____ Home Phone _____ Work Phone _____	

Employer	Employer's Name _____ Work Phone _____
	Address _____ City _____ State _____ Zip _____

Referring MD	Referring MD Name _____ Ref MD Phone # _____
	Address _____ City _____ State _____ Zip _____

Primary MD	Primary Care MD Name _____ MD Phone # _____
	Address _____ City _____ State _____ Zip _____

Responsible Party	Last name _____ First Name _____ Initial _____
	Address _____ City _____ State _____ Zip _____
	Phone _____ Date of Birth _____ SS# _____ E-mail address _____

Primary Insurance	Insurance Company _____ Group # _____ Member # _____
	Insured's Name _____ Relationship to Patient _____ Date of Birth _____
	Employer's Name _____ Employer's Address _____

Secondary Insurance	Insurance Company _____ Group # _____ Member # _____
	Insured's Name _____ Relationship to Patient _____ Date of Birth _____
	Employer's Name _____ Employer's Address _____

****There will be a \$35.00 charge for returned checks**.**

To Help Prevent Identity Theft, Federal Law Requires Us to ask for a Photo ID

<p>Authorization to Pay Benefits to CANH</p> <p>I hereby authorize payment directly to the Physician for the medical and/or surgical benefits. I understand that I am responsible to pay for non covered services, co-payments and deductibles & for any other balances for which I am responsible under my insurance plan</p> <p>Signature: _____ Date: _____</p>	<p>Authorization to Release Information</p> <p>I hereby authorize CANH to release any medical or billing information acquired in the course of my treatment to my insurance company/plan or to my primary and/or referring physician.</p> <p>Signature: _____ Date: _____</p>
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