B. EUGENE BERRY, M.D.
CARLTON H. SHEELY II, M.D.
R. SCOTT THURSTON, M.D.
C. SWAYZE RIGBY, M.D.
WALTER L. BRINGAZE III, M.D.

PATIENT REGISTRATION FORM

CVT SURGICAL CENTER
HEART • CIRCULATORY • LUNG

P. MICHAEL DAVIS, JR., MD
MICHAEL S. CONNERS III, MD
JAMES E. CRAVEN IV, MD
JAMES W. MCNEIL, MD
WILLIAM M. BOEDEFELD II, MD

(Please print)

Today's Date: ___/___/___ Patient's reason for visit: _____

First Name: _____ Middle: _____ Last _____ Sex : Male Female

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ___/___/___ SS#: _____ Home Phone: _____ Cell Ph: _____

Referring Physician: _____ Family Physician: _____

Is the Patient employed? Yes❒ (Full Time ❒ / Part Time ❒) No ❒ E-mail: _____

Employer: _____ Position: _____ Employer Phone: _____

Retired ❒ Retired from: _____ Year retired: _____

Marital Status: Single ❒ Married ❒ Widowed ❒ Divorced ❒

If minor, list Responsible Party: _____

Spouses Name: _____ Spouse's SS#: _____

Spouses Employer: _____ Employer Phone: _____

In case of emergency - Name of Nearest Relative Not Living at Same Address: _____ Phone: _____

PRIMARY INSURANCE COMPANY: _____

Group #: _____ Policy #: _____

Effective Date: _____ Policy Holder: _____ D.O.B.: ___/___/___ Ins. Phone: _____

SECONDARY INSURANCE COMPANY: _____

Group #: _____ Policy #: _____

Effective Date: _____ Policy Holder: _____ D.O.B.: ___/___/___ Ins. Phone: _____

ADDITIONAL INSURANCE COVERAGE: _____

Group #: _____ Policy #: _____

Effective Date: _____ Policy Holder: _____ D.O.B.: ___/___/___ Ins. Phone: _____

ASSIGNMENT / MEDICAL RECORD RELEASE AUTHORIZATION

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to CVT SURGICAL CENTER, AMC or CVT VASCULAR LAB, INC. for any services furnished me by these providers. I authorize any holder of medical information about me to release to Health Care Financing Administration or other insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for all charges at all times.

Date: _____ Signature of Patient or Authorized Representative: _____