

**THE CARDIOVASCULAR SPECIALISTS, LLC**  
90 TER HEUN DRIVE, SUITE 300 • FALMOUTH, MA 02540  
(508) 540-0604  
www.tcsma.com

**PATIENT INFORMATION**

PATIENT NAME: (Last, First, M.I.) _____	REFERRING PHYSICIAN: _____
POST OFFICE BOX: _____	EMPLOYER: _____
STREET ADDRESS: _____	WORK PHONE: (_____) _____
CITY, STATE: _____	CELL PHONE: (_____) _____
ZIP CODE: _____	HOME PHONE NO: (_____) _____
SOCIAL SECURITY NO: _____ - _____ - _____	PATIENT SEX: M F _____ MARITAL STATUS: _____ AGE: _____
DATE OF BIRTH: _____	STUDENT (Y/N) _____
<b>IN CASE OF EMERGENCY WHO SHOULD WE CALL: NAME:</b> _____ <b>PHONE NO:</b> (____) _____	

**GUARANTOR INFORMATION** (Person responsible for payment of Personal balance)  
**PLEASE COMPLETE IF OTHER THAN PATIENT IS RESPONSIBLE**

GUARANTOR NAME: (Last, First, M.I.) _____	PHONE NO: (_____) _____
ADDRESS: _____	CITY, STATE: _____
BIRTH DATE: _____	SEX: M F _____ GUARANTOR SOCIAL SECURITY NO: _____ - _____ - _____

**INSURANCE INFORMATION** (Please give your insurance cards to the front desk so they may be scanned)

PRIMARY INSURANCE COMPANY ID #: _____	GROUP #: _____
NAME OF INSURANCE COMPANY: _____	
MAILING ADDRESS FOR CLAIMS: _____	
SUBSCRIBER: SELF _____ SPOUSE _____ OTHER _____ - If you checked spouse or other please complete the information below.	
SUBSCRIBERS NAME: _____ SUBSCRIBER'S RELATIONSHIP TO YOU IF NOT A SPOUSE: _____	
SUBSCRIBER'S ADDRESS: _____	
SUBSCRIBER'S PHONE NO: (_____) _____ BIRTHDATE: _____ SEX: M F	
EMPLOYER: _____ WORK PHONE NO: (_____) _____	
DOES YOUR INSURANCE HAVE A CO-PAYMENT ON OFFICE VISITS? YES _____ NO _____ AMOUNT OF CO-PAYMENT: \$ _____	

SECONDARY INSURANCE COMPANY ID _____	GROUP #: _____
NAME OF INSURANCE COMPANY: _____	
MAILING ADDRESS FOR CLAIMS: _____	
SUBSCRIBER: SELF _____ SPOUSE _____ OTHER _____ - If you checked spouse or other please complete the information below.	
SUBSCRIBERS NAME: _____ SUBSCRIBER'S RELATIONSHIP TO YOU IF NOT A SPOUSE: _____	
SUBSCRIBER'S ADDRESS: _____	
SUBSCRIBER'S PHONE NO: (_____) _____ BIRTHDATE: _____ SEX: M F	
EMPLOYER: _____ WORK PHONE NO: (_____) _____	
DOES YOUR INSURANCE HAVE A CO-PAYMENT ON OFFICE VISITS? YES _____ NO _____ AMOUNT OF CO-PAYMENT: \$ _____	

If your insurance requires a referral, (such as Pilgrim Health, Bay State or Blue Shield HMO) make sure we have received it.  
Are you being seen by us for an automobile injury? YES \_\_\_\_\_ NO \_\_\_\_\_  
Are you being seen for a Workman's Compensation Case? YES \_\_\_\_\_ NO \_\_\_\_\_  
If you are being seen for either an auto related accident and/or a Workman's Comp Case, make sure to provide us with the complete case number and who should be billed.

**BILLING AUTHORIZATION**

I HEREBY AUTHORIZE THE CARDIOVASCULAR SPECIALISTS, LLC, INC. TO FURNISH INFORMATION TO THE INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT. I HEREBY ASSIGN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_