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*Ablation, Lead Extraction, P.H., FRCR,
CRD*

*James Ong, MD, FACC, FAPC
Carlos M. Alves, MD, FACC*

Patient Registration Form

(Please fill in as completely as possible and correct any mistakes in the pre-filled boxes.)

	Date:	Dr. License:
Lastname:	Firstname:	Home Phone:
Address:	City:	State/Zip:
Social Sec #:	Birth Date:	Marital Status:
Who Referred you?	Employer:	Work Phone:
Employee Address:		
Spouse Name:		Spouse Employer:
Emergency Contact (relationship/phone#):		

PRIMARY INSURANCE INFORMATION: (please provide a copy of your insurance card)		
Insurance Name/Address:		
Subscriber:	Subscriber#:	Group Name:
Group#:	Subscriber DOB:	Subscriber SSN:

SECONDARY INSURANCE INFORMATION: (please provide a copy of your insurance card)		
Secondary Insurance Name/Address:		
Subscriber:	Subscriber#:	Group Name:
Group #:	Subscriber DOB:	Subscriber SSN:

Your Email Address:	Your Fax number:
Cell Phone #:	

I hereby authorize all insurance benefits to be paid directly to VALLEY REGIONAL ARRHYTHMIA CENTER, INC. I understand that I am responsible for charges as designated by my insurance companies (e.g. deductibles, co-payments). I am also responsible for all charges not covered by insurance, and for any finance fees incurred on unpaid balances. I authorize VALLEY REGIONAL ARRHYTHMIA CENTER, INC. to release any information to my insurance companies when requested by them.

Signed: _____