

**Naugatuck Valley Cardiovascular Associates**

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Southbury, CT 06488  
TOLL FREE: 866-621-NVCA (6822)

205 So. Main Street  
Thomaston, CT 06787

**PATIENT REGISTRATION FORM**

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**Patient Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

Preferred form of address: Mr. Mrs. Ms. Miss Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #'s: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Social Security No. \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Responsible Party if other than Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone# \_\_\_\_\_

Who referred you to us? \_\_\_\_\_ Who is your Primary Care Doctor? \_\_\_\_\_

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**Insurance Information: Please be sure to present your insurance cards.**

Primary Insurance

Secondary Insurance

Insurance Name: \_\_\_\_\_

Insurance Name \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

Phone # \_\_\_\_\_

Name on Policy \_\_\_\_\_

Name on Policy \_\_\_\_\_

Policy # \_\_\_\_\_

Policy # \_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

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**Release of Information Authorization:**

I hereby authorize release of Medical Benefits directly to Naugatuck Valley Cardiovascular Associates. I understand that even though I have some type of insurance, I may be responsible for payment of service either in full or in part. I also authorize release of Medical Information necessary to process my insurance claims for services provided by Naugatuck Valley Cardiovascular Associates.

I have received a copy of NVCA's HIPAA Privacy Notice. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT ME MAY BE USED AND DISCLOSED BY THIS PROVIDER AND HOW I CAN GET ACCESS TO THIS INFORMATION