Connecticut Cardiothoracic Surgical Associates, L.L.C.

Henry B.C. Low, M.D.
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David J. Underhill, M.D.
Daniel S. Fusco, M.D.

Name_____
First middle last

Address_____
Street city state zip

Home Telephone _____ Date of Birth _____Age_____

Employer _____Work Phone _____Cell Phone_____

Social Security Number _____Marital Status_____

Spouse/person to notify in case of emergency:_____

Relationship _____home phone _____work phone _____

Someone NOT living with you we can contact in case of emergency:

Name_____Relationship_____Phone_____

Doctor Referred by _____ Primary Physician_____

Reason for Visit _____

INSURANCE INFORMATION (We will need to copy cards along with a photo ID)

Primary Insurance _____ID #_____

Secondary Insurance _____ID#_____

1. Patients undergoing open heart surgery should be aware that an assistant surgeon is used during the procedure and a separate fee will be charged.
2. Your insurance will be filed as a courtesy to you. All services not paid within 30 days by your insurance company will become your responsibility.
3. All copays, deductibles, co-insurance, previous balances and fees for non-covered services are due at the time of your visit.
4. YOU are responsible for knowing the benefits/coverage of your insurance. In the event your insurance company does not cover any services, you will be responsible.
5. Occasionally the services of a Visiting Nurse are needed during the first few days home from the hospital. Please check with your health insurance to verify coverage of these services.

Signature _____ Date _____

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