



**PATIENT INFORMATION**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Marital status: Married Divorced Widowed Single Sex: M F Email: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer address: \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I. SPOUSE INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer address: \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**II. INSURANCE INFORMATION**

Medicare: Yes No Medicare# \_\_\_\_\_ Is Medicare Primary: Yes No

Medi-Cal: Yes No Medi-Cal# \_\_\_\_\_ Blue Cross Medi-Cal: Yes No

**PRIMARY INSURANCE** Name of Company \_\_\_\_\_

Group# \_\_\_\_\_ Policy# \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber name: ( policy holder ): \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

**SECONDARY INSURANCE** Name of company \_\_\_\_\_

Group# \_\_\_\_\_ Policy# \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber name: (policy holder) \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

Referring Physician : \_\_\_\_\_

Other physicians you are seeing: \_\_\_\_\_



**The Heart Center 5020 Commerce Dr. Bakersfield, CA 93309**

**Patient name:** \_\_\_\_\_

**IV. EMERGENCY INFORMATION** Provide information on nearest relative (not your spouse) who does not live with you.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_

\_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**V. SIGNATURE** The above information is true and correct to the best of my knowledge.

X \_\_\_\_\_

Signature of Patient or Responsible Party

Date

**VI. ASSIGNMENT OF INSURANCE BENEFITS**

I hereby assign all medical and/or surgical benefits to which I may be entitled from an Insurance plan(s) to the practicing physicians of **The Heart Center**. This assignment will remain in effect until revoked by me in writing. I hereby authorize said assignee(s) to release all information necessary to secure payment of said benefits.

Date: \_\_\_\_\_ Patient signature: \_\_\_\_\_

Insured signature: \_\_\_\_\_

**VII. CONSENT TO RELEASE INFORMATION**

I hereby authorize the practicing physicians of **The Heart Center** to furnish information to any agency, attorney or insurance company (ies) as is necessary.

Date: \_\_\_\_\_ Patient signature: \_\_\_\_\_

**VIII. MEDICARE ASSIGNMENT**

I request that payment of authorized Medicare benefits be made to the practicing physicians of **The Heart Center** for any services furnished to me by those physicians / suppliers.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services.

Date: \_\_\_\_\_ Patient signature: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE / REQUEST OF MEDICAL RECORDS**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Understanding the confidentiality of medical records, I, as the patient or legally responsible party for the patient mentioned below, hereby authorize the release of medical records of the below named patient to:

**THE HEART CENTER  
5020 Commerce Dr.  
BAKERSFIELD, CA 93309  
(661) 324-4100**

**PATIENT:** Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Signature of patient / responsible party: \_\_\_\_\_

Relationship of responsible party to patient \_\_\_\_\_

Today's date: \_\_\_\_\_