

I. MINOR / CHILD PATIENT INFORMATION

Name: _____ Age: _____
Date of birth: _____ SS#: _____
Sex: Male Female Drivers License #: _____ Email: _____
Home address: _____ City: _____
State: _____ Zip: _____ Phone: (_____) _____

II. RESPONSIBLE PARTY

Father's Name: _____ **DOB:** _____
SS#: _____ - _____ - _____ **Drivers License#:** _____
Employer: _____ **Occupation:** _____
Employer address: _____ **Work Phone:** (_____) _____
City: _____ **State:** _____ **Zip:** _____
Mother's Name: _____ **DOB:** _____
SS#: _____ - _____ - _____ **Drivers License#:** _____
Employer: _____ **Occupation:** _____
Employer address: _____ **Work Phone:** (_____) _____
City: _____ **State:** _____ **Zip:** _____

III. INSURANCE INFORMATION

Medi-Cal: **Yes** **No** Medi-Cal# _____

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: _____

PATIENT NAME: _____ **DOB:** _____

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.

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

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

Date: _____ Patient/ Guardian 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/Guardian signature: _____

Date: _____ Patient signature: _____

PATIENT NAME: _____ **DOB:** _____

AUTHORIZATION FOR RELEASE / REQUEST OF MEDICAL RECORDS

To: _____

Understanding the confidentiality of medical records, I, as the patient or a legal 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.
BAKERSFIED, 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: _____