Pacific Pediatric Cardiology Medical Group, Inc.

Patient Information

Patient's Name: ________________________ Date of Birth: __________ Age: ________ Sex M / F

Address: ________________________ City: ____________ State: ______ Zip Code: ________

Home Phone#: ______________ Cell# 1: ______________ Cell# 2: ______________

Email: ____ ❑ None Available ❑ Refused

Primary Language spoken: ____________________ Religion: ________________________

Ethnicity and Race: (Check One) ❑ Hispanic or Latino ❑ American Indian or Alaska Native ❑ Black or African American ❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ Asian ❑ Other Race ______________ ❑ Declined to State

Mother's/Guardian Name: ________________________________ Date of Birth: ____________

Social Security #: ____________________ Drivers License: ______________________

Father's/Guardian Name: ________________________________ Date of Birth: ____________

Social Security #: ____________________ Drivers License: ______________________

Parents / Guardian Employer Information

Father/Guardian employer: ________________________________ Telephone: ____________

Address: ________________________ City: ____________ State: ______ Zip Code: ________

Mother/Guardian employer: ________________________________ Telephone: ____________

Address: ________________________ City: ____________ State: ______ Zip Code: ________

Insurance Information

Primary Insurance Company: ____

Primary Ins. Co. Telephone: ______________ Main Subscriber Name: ______________________

Policy#: ________________________ Group#: ______________________________

Secondary Insurance Company: ____

Secondary Ins. Co. Telephone: ______________ Group#: ______________________________

In Case of Emergency Nearest Relative or Friend:

Name: ________________________ Telephone: ______________________________

Primary Care Physician

Name: ________________________________ Telephone: ______________________

Address: ________________________________ City: ________________ Zip Code: ________

Assignment of Benefits and Release of Information

I hereby authorize payment directly to Pacific Pediatric Cardiology Medical Group, Inc. of the insurance benefits otherwise payable to me. I understand that I am responsible for the charges not covered by the insurance. I authorize that a photo copy of this authorization is as if such were original. If it becomes necessary for the account to be sent to an attomey for collection or suit, the undersigned shall pay the reasonable attorney fees and collection expenses including court costs. I authorize the treating physician to release any information acquired in the course of my examination or treatment. I also authorize access to my prescription history.

____

Date **Signature (Parent or Legal Guardian)**