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 attorney 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)**