

SOUTHERN CALIFORNIA HEART SPECIALISTS

PATIENT INFORMATION (Please fill out completely)

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Social Security Number: _____
Gender: ()Female ()Male Marital Status: ()Single ()Married ()Other
Home Street Address: _____ Apartment or Unit: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Mobile: _____
Email Address: _____
Emergency Contact: _____
Emergency Phone Number: _____

RESPONSIBLE PARTY INFORMATION (if different from the above)

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Social Security Number: _____
Gender: ()Female ()Male
Home Street Address: _____ Apartment or Unit: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Mobile: _____
Relationship: ()Patient is Self ()Patient is Spouse ()Patient is Child ()Other

INSURANCE INFORMATION

Primary Insurance Company (1st Payer): _____

Member ID: _____ Group ID: _____
Insured Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: ()Female ()Male
Relationship: ()Patient is Self ()Patient is Spouse ()Patient is Child ()Other

Secondary Insurance Company (2^d Payer): _____

Member ID: _____ Group ID: _____
Insured Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: ()Female ()Male
Relationship: ()Patient is Self ()Patient is Spouse ()Patient is Child ()Other

I hereby authorize payment directly to Southern California Heart Specialists (SCHS) in consideration of acceptance for services rendered and to be rendered to me by any physician associate or professional staff member. I understand that I am financially responsible for the charges not covered by this authorization. I further agree in the event of non-payment, to bear the cost of reasonable legal and attorney fees should this be required.

I hereby authorize SCHS to disclose when requested by the named insurance carrier or its representatives any and all information with respect to any illness(es), medical history, or treatment and copies of all medical records. A photo-static copy of the authorization shall be considered as effective and valid as the original.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, IS THE PATIENT, OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT, TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS, OR IS THE INSURED.

(SIGNATURE OF THE RESPONSIBLE PERSON)

(DATE)