Children's Heart Center of El Paso

ALL INFORMATION SHOULD BE PROVIDED (please print)

PATIENT INFORMATION

MR#

Patient's Name	Birth date	Age	Sex F M	Home Phone ( )
Address	City State	Zip		Cell Phone Number ( )
Patient's Social Security Number	Race (please circle) African American Caucasian Hispanic Other_____	Language English Spanish		Marital Status Single Married Divorced Widowed
Employer or Name of School	Business Phone			
Referring Doctor:	Primary Care Provider:			

PRIMARY RESPONSIBLE PARTY INFORMATION

Name		Address		
City	State	Zip	Relationship to Patient	Employer Name
Social Security Number - -	Date of Birth	Home Number	Business Phone ( )	Cell Phone Number ( )

SECONDARY RESPONSIBLE PARTY INFORMATION

Name		Address		
City	State	Zip	Relationship to Patient	Employer Name
Social Security Number - -	Date of Birth	Home Number	Business Phone ( )	Cell Phone Number ( )

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU

Name	Relationship	Home Number		
Cell phone number				

GROUP OR PERSONAL INSURANCE INFORMATION

(Please present insurance card(s) to Receptionist)

PRIMARY CARRIER		**SECONDARY CARRIER**	
Ins. Name Phone ( )		Ins. Name Phone ( )	
Address		Address	
Employer, if group coverage		Employer, if group coverage:	
Policy Number	Group Number	Policy Number:	Group Number
Subscriber's Name	Date of Birth	Subscriber's Name	Date of Birth

PLEASE READ BEFORE SIGNING: I authorize Children's Heart Center of El Paso to release any medical record information that may be necessary to any hospital, clinic or physician for medical purposes.

I authorize Children's Heart Center of El Paso to release medical information that may be necessary to request reimbursement from insurance companies to who I have submitted a claim. I assign all medical and surgical benefits to include major medical benefits to which I am entitled to Children's Heart Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **I understand that I am financially responsible for all charges whether or not paid by said insurance, including co-payments at the time of service.** I understand that any overpayment on my account will be promptly refunded. If an account is established, I authorize Children's Heart Center to run a credit report when necessary in regards to my account. I understand that this form must be updated annually. I hereby consent to permit Children's Heart Center to render medical services and counsel to me.

SIGNATURE OF RESPONSIBLE PARTY _____ **DATE** _____