Pediatric Heart Center

How well do you speak English: ____ Very well ___ Well ____Not well ____Not at all
Language: _______________

Patient Name: ____ Sex: (F) or (M)
Date of Birth : ________________ SS# : ____________________________
Address: ____ Apt#______________
City:______________________________ State: _______ Zip:___________
Home Phone Number: ______________________________

Mother's Name: ___________________________________ Date of Birth: __________________
SS# :_______________________________
Address: ____ Apt#:______________
City: _________________________ State: _______ Zip: ___________
Home Number: ___________________
Employer: ________________________ Work Number: _______________________
Cell Number: _____________________

Father's Name: ___________________________________ Date of Birth: ___________________
Address: ____ Apt#:________________
City: _______________________________ State: ________ Zip: ___________
SS# :____________________________ Home Number: _____________________
Employer: ______________________________ Work Number: ______________________
Cell Number: ___________________________

Email: ____
Emergency Contact: ___________________________ Relationship:_______________________
Phone Number: _________________________ Cell: _____________________________

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Name of Pediatrician: ____
Address: ____ Suite#:_________________
City: ____________________________ State: _______ Zip: _______
Phone Number: ___________________

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Health Insurance Information

Insurance Company: ____
Policy #: _______________________________ Group #: _________________________
Address: ____
Name of Insured: ____

Secondary Insurance:____
Policy #: ______________________________ Group #:_________________________
Address:____
Name of Insured: ____

CONSENT FOR TREATMENT…AUTHORIZATION FOR ASSIGMENT OF BENEFITS AND INFORMATION RELEASE

PARTICIPATING INSURANCE:- I hereby assign to this Practice, my physician or other healthcare professionals involved in my care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available, to pay for all services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. I understand that I am responsible for all charges (hospital and/or physician) until the bills are paid in full and for the balance of charges not covered by insurance.

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Parent or Legal Guardian Date