

FOR OFFICE USE ONLY	
Date	Account #

PATIENT INFORMATION - Please Fill Out Completely

Last Name		First Name		Middle Initial	
Street Address			City	State	Zip
Billing Address (if different from above)			City	State	Zip

Marital Status Single Married Divorced Widowed Separated

Home Telephone # ()		Work Telephone # ()		Cell # ()	
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #			

EMPLOYER INFORMATION

Name		Employer Telephone #			
Address		City	State & Zip		

IN CASE OF AN EMERGENCY, NEAREST RELATIVE / FRIEND NOT RESIDING AT THE SAME RESIDENCE

Name		Relation	Telephone # ()	
------	--	----------	-----------------------	--

INSURANCE INFORMATION

Name of Primary Insurance			Policy Number		
Group Number			Subscriber's Number		
Name of Secondary Insurance			Policy Number		
Group Number			Subscriber's Number		

PHYSICIAN INFORMATION

Referring Physician		Telephone #	Other
Primary Care Physician		Telephone #	Other

ASSIGNMENT & RELEASE

I hereby authorize The Hollywood Heart Center to release any medical information necessary to process any and all claims filed by them. I understand that I am financially responsible for all charges incurred, regardless of what insurance coverage I may currently have. I hereby authorize payment directly to The Hollywood Heart Center for all insurance services performed as specified on the attached insurance claims.

I hereby authorize any hospital and/or physician to disclose and release to The Hollywood Heart Center any and all information that may have been obtained in connection with physical examination or surgical and/or medical treatment with the understanding that any information obtained will be treated as confidential.

Signature _____ Date _____