Patient Registration

(Please Print)

GENERAL INFORMATION

Last ______________ **First** ______________ **Middle** ______________
Date of Birth ______________ **Social Security Number** ______________
Sex ❏ **M** ❏ **F** **Drivers License #** ______________ **State** ______________
Marital Status: ❏ **Married** ❏ **Single** ❏ **Domestic Partner** ❏ **Divorced** ❏ **Widowed**
Parent/Guardian Name ______________ **Relationship** ______________
In Case of Emergency Contact ______________ **Phone** ______________

ADDRESSES

Home Address ______________ **City** ______________ **State** ______ **Zip** ______
Home Phone ______________ **Cell Phone** ______________
Email Address ______________

Employer ______________
Occupation ______________
Work Address ______________ **City** ______________ **State** ______ **Zip** ______
Work Phone ______________ **Email Address** ______________

INSURANCE INFORMATION

Name of Primary Insurance Co ______________ **Phone** ______________
ID/Policy Number ______________ **Group Number** ______________
Subscriber/Insured ______________ **Relationship** ______________ **Sex** ______
Date of Birth ______________ **Social Security Number** ______________
Employer Name ______________ **Employer Phone** ______________

Name of Secondary Insurance Co ______________ **Phone** ______________
ID/Policy Number ______________ **Group Number** ______________
Subscriber/Insured ______________ **Relationship** ______________ **Sex** ______
Date of Birth ______________ **Social Security Number** ______________
Employer Name ______________ **Employer Phone** ______________

I, the undersigned, assign directly to Pacific Coast Cardiology all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Signature ______________ Date ______________
(If the patient is a minor, signature of parent or guardian authorizing treatment)