Sanger Clinic

PEDIATRIC CARDIOLOGY – PATIENT INFORMATION

(Please Print)

Doctor: _____ Chart #: _____ Date: _____

(Please complete information below) Location:_____

PATIENT NAME (Please Print) LAST FIRST MIDDLE	SS #	BIRTH DATE	AGE	SEX M F	MARITAL STATUS S M D W

STREET ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE #
PATIENT EMPLOYER	ADDRESS/CITY/STATE	ZIP CODE	WORK PHONE #

WHO REFERRED YOU TO THIS OFFICE? Full Name & Phone #	FAMILY DOCTOR/PEDIATRICIAN? Full Name/Address

EMERGENCY CONTACT (Relationship)	ADDRESS/CITY/STATE	ZIP CODE	WORK & HOME PHONE #

MOTHER or WIFE **FULL NAME** (circle one)	BIRTH DATE	SS #	FATHER or HUSBAND **FULL NAME** (circle one)	BIRTH DATE	SS #

HOME ADDRESS	CITY/STATE	ZIP CODE	HOME ADDRESS	CITY/STATE	ZIP CODE
EMPLOYER NAME	ADDRESS/CITY/STATE	ZIP CODE	EMPLOYER NAME	ADDRESS/CITY/STATE	ZIP CODE
HOME PHONE #	WORK PHONE #	Dept./Ext.	HOME PHONE #	WORK PHONE #	Dept./Ext.

PRIMARY INSURANCE (fill in below)	**INSURANCE COVERAGE THROUGH SELF / MOTHER / FATHER / SPOUSE (circle one)**			
INSURANCE COMPANY NAME	TELEPHONE #	EFFECTIVE DATE	POLICY ID #	GROUP #
POLICY HOLDER NAME		EMPLOYER BUSINESS		PHONE #
POLICY HOLDER DATE OF BIRTH		POLICY HOLDER SS #		RELATIONSHIP TO PATIENT
CLAIMS MAILING ADDRESS CITY/STATE			ZIP CODE	TYPE OF POLICY: ___ PPO ___ HMO ___ POS

SECONDARY INSURANCE (fill in below)	**INSURANCE COVERAGE THROUGH SELF / MOTHER / FATHER / SPOUSE (circle one)**			
INSURANCE COMPANY NAME	TELEPHONE #	EFFECTIVE DATE	POLICY ID #	GROUP #
POLICY HOLDER NAME		EMPLOYER BUSINESS		PHONE #
POLICY HOLDER DATE OF BIRTH		POLICY HOLDER SS #		RELATIONSHIP TO PATIENT
CLAIMS MAILING ADDRESS CITY/STATE			ZIP CODE	TYPE OF POLICY: ___ PPO ___ HMO ___ POS

MEDICARE NUMBER	**EFFECTIVE DATE** PART A ____ PART B ____	**MEDICAID NUMBER**	**STATE**	**VALID DATES** FROM _____ TO _____

PERSON RESPONSIBLE FOR PAYMENT	ADDRESS/CITY/STATE/ZIP CODE	PHONE NUMBER

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby assign payment of the medical and/or major medical benefits, if any, otherwise payable to me for this service, directly to the designated physician and/or the Sanger Clinic. This authorization is valid for any and all insurance claims filed for me by the Sanger Clinic to the insurance companies listed above. This authorization is valid from this date until written notice of cancellation is received in the offices of the Sanger Clinic.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SANGER CLINIC AND/OR DESIGNATED PHYSICIAN FOR CHARGES NOT COVERED OR PAID BY THIS ASSIGNMENT.

I hereby authorize the designated physician to release any information acquired in the course of my examination and treatment to the insurance company(ies) listed above, and any other physician or health care facility where the Sanger Clinic may refer me for further care.

_____ _____

Signed Insurance Holder Date Signed Responsible Individual Date