Children's Heart Clinic

PATIENT REGISTRATION FORM

Last Name	First	Middle	Date of birth	Gender (circle) M F	Social Security #
Address	Apt. #	City		State	Zip Code
Home Phone	Pediatrician/Referring Doctor		Address		Doctor Phone

Mother/Guardian Last Name	First	Middle		Home Phone	Social Security #
Address	Apt. #	City	State	Zip Code	Date of Birth
Employer Name/Address		Work Phone		Cell Phone	E-Mail Address
Father/Guardian Last Name	First	Middle		Home Phone	Social Security #
Address	Apt. #	City	State	Zip Code	Date of Birth
Employer Name/Address		Work Phone		Cell Phone	E-Mail Address

Primary Insured's Name	Address (if different from above)		Social Security #	Date of Birth
Insurance Company	Phone Number	Policy Number	Group Number	Relation to Patient

Emergency Contact	Home phone	Cell phone	Relationship
Preferred Pharmacy Name	Address		Phone

Authorized Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of medical benefits to the assigned physician for services rendered. I understand that submittal of a claim is not a guarantee of payment and that I am financially responsible for all charges on this account.

Print name/Relationship to patient: _____ **Date:** _____

Signature: _____