

PEDIATRIC CARDIOLOGY, P.C.

PATIENT INFORMATION

PATIENT NAME _____ BIRTH DATE _____ AGE ___ SEX ___

PARENT or SPOUSE'S NAMES _____

PATIENT ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # () _____ Language: English Spanish Arabic Burmese

CELL PHONE # () _____ French German Chinese Other: _____

Patient's Race: (Circle) Caucasian; Black/African American; Hispanic; Asian; Pacific Islander
Native Hawaiian; Native American; Other _____

MOTHER _____ FATHER _____ SPOUSE _____

WORK PH # _____ WORK PH # _____ WORK PH # _____

EMPLOYER _____ EMPLOYER _____ EMPLOYER _____

BIRTH DATE _____ BIRTH DATE _____ BIRTH DATE _____

CELL PH # _____ CELL PH # _____ CELL PH # _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE # _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

PRIMARY CARE PHYSICIAN ADDRESS _____

In order to establish optimal relations with our patients in regard to our payment policies, **PAYMENT IS EXPECTED AT TIME OF SERVICE** for "Your Part" of the charges. the Adult/Guardian who brings in a minor will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees. Your signature below indicates that you understand and accept this policy. You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed. This signature also indicates that you are aware of your HIPPA rights; a copy is available upon request.

Signature of Patient/Legal Guardian Date