



# NEW PATIENT INFORMATION

(PLEASE PRINT)

DATE \_\_\_\_\_

PATIENTS NAME			MARITAL STATUS					DATE OF BIRTH	AGE	S.S.#	
			S	M	W	D	SEP				
STREET ADDRESS		PERMANENT	TEMPORARY	CITY AND STATE				ZIP CODE	HOME PHONE#		
PATIENTS OR PARENTS EMPLOYER				OCCUPATION (INDICATE STUDENT)				HOW LONG EMPLOYED	BUS PHONE #		
EMPLOYERS STREET ADDRESS				CITY AND STATE			ZIP CODE	EMAIL ADDRESS			
DRUG ALLERGIES, IF ANY								DRIVERS LIC. #			
SPOUSE OR PARENTS NAME					S.S. #			NUMBER OF CHILDREN AND AGES			
SPOUSE OR PARENTS EMPLOYER				OCCUPATION (INDICATE STUDENT)				HOW LONG EMPLOYED	BUS PHONE #		
EMPLOYERS STREET ADDRESS				CITY AND STATE				ZIP CODE			
SPOUSE DATE OF BIRTH											

### IN CASE OF EMERGENCY, PERSON TO NOTIFY (Not living at same address)

**NAME** \_\_\_\_\_ **PHONE** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE			STREET ADDRESS, CITY, STATE @ ZIP CODE				HOME PHONE #	
BLUE SHIELD (GIVE NAME OF POLICY HOLDER)			EFFECTIVE DATE	CERTIFICATE #	GROUP #	COVERAGE CODE		
<input type="checkbox"/>								
OTHER (WRITE IN NAME OF INSURANCE COMPANY)			MAILING ADDRESS				POLICY #	
<input type="checkbox"/>								
OTHER (WRITE IN NAME OF INSURANCE COMPANY)			MAILING ADDRESS				POLICY #	
<input type="checkbox"/>								
MEDICARE (PLEASE GIVE NUMBER)					RAILROAD RETIREMENT (PLEASE GIVE NUMBER)			
<input type="checkbox"/>								
INDUSTRIAL	WERE YOU INJURED ON THE JOB?		DATE OF INJURY		INDUSTRIAL CLAIM #			
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>							
ACCIDENT	WAS AN AUTOMOBILE INVOLVED		DATE OF ACCIDENT		NAME OF ATTORNEY			
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>							
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE?								
REFERRED BY			STREET ADDRESS, CITY, STATE AND ZIP CODE				PHONE#	

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

## INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE CARDIOLOGY SPECIALIST OF ORANGE COUNTY TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

**DATE** \_\_\_\_\_ **SIGNATURE** \_\_\_\_\_