

Please help us serve you better by taking a few minutes to provide the following information. PLEASE PRINT CLEARLY

PATIENT INFORMATION

Last Name: _____ Marital Status: Single Married Divorced Widowed X-Separated
Last First MI

Address: _____ Race/Ethnicity: C-Caucasian H-Hispanic/Latin B-African American
 A-Asian I-American Indian/Alaskan Native
 J-Native Hawaiian P-Pacific Islander E-Other

City: _____ State: _____ Zip: _____

Date of Birth _____ Check if minor (less than 18) Gender: M F 1st Language: English Spanish Other _____

Soc. Sec. # _____ Driver's License # _____ 2nd Language: English Spanish Other _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Employer: _____ Work Phone: _____

Employer Address: _____ Work Hours: _____

Primary Care Physician (Full Name) _____ Primary Physician Phone: _____

Referring Physician (Full Name) _____ Referring Physician Phone: _____

SPOUSE/PARENT OR GUARDIAN INFORMATION

Last Name: _____ Marital Status: Single Married Divorced Widowed X-Separated
Last First MI

Address: _____ Race/Ethnicity: C-Caucasian H-Hispanic/Latin B-African American
 A-Asian I-American Indian/Alaskan Native
 J-Native Hawaiian P-Pacific Islander E-Other

City: _____ State: _____ Zip: _____

Date of Birth _____ Gender: M F 1st Language: English Spanish Other _____

Soc. Sec. # _____ Driver's License # _____ 2nd Language: English Spanish Other _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Employer: _____ Work Phone: _____

Employer Address: _____ Work Hours: _____

OTHER PARENT OR GUARDIAN INFORMATION

Last Name: _____ Marital Status: Single Married Divorced Widowed X-Separated
Last First MI

Address: _____ Race/Ethnicity: C-Caucasian H-Hispanic/Latin B-African American
 A-Asian I-American Indian/Alaskan Native
 J-Native Hawaiian P-Pacific Islander E-Other

City: _____ State: _____ Zip: _____

Date of Birth _____ Gender: M F 1st Language: English Spanish Other _____

Soc. Sec. # _____ Driver's License # _____ 2nd Language: English Spanish Other _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Employer: _____ Work Phone: _____

Employer Address: _____ Work Hours: _____

EMERGENCY CONTACT INFORMATION

Name of Closest Relative Not Living With You: _____

Relationship to Patient: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Plan Phone: _____

Name of Person Insured: _____ Policyholder's DOB _____ Gender: M F

Soc Sec # _____ Employer: _____ Patient Relationship: Self Child Stepchild Spouse Other _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policy ID# _____ Group # _____ Group Name _____

Type of Coverage: Group Individual Cobra Is this a Retiree Plan? Yes No

Secondary Insurance Company: _____ Plan Phone: _____

Name of Person Insured: _____ Policyholder's DOB _____ Gender: M F

Soc Sec # _____ Employer: _____ Patient Relationship: Self Child Stepchild Spouse Other _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policy ID# _____ Group # _____ Group Name _____

Type of Coverage: Group Individual Cobra Is this a Retiree Plan? Yes No

Last Name: _____ First Name: _____ DOB: _____

INSURANCE INFORMATION CONT.

Tertiary Insurance Company: _____ Plan Phone: _____
Name of Person Insured: _____ Policyholder's DOB _____ Gender: M F
Soc Sec # _____ Employer: _____ Patient Relationship: Self Child Stepchild Spouse Other
Claims Address: _____ City: _____ State: _____ Zip: _____
Policy ID# _____ Group # _____ Group Name _____
Type of Coverage: Group Individual Cobra Is this a Retiree Plan? Yes No
 I have a special situation that affects our insurance coverage such as a divorce decree and/or custody issues.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to the physician's of Children's Heart Center (CHC) of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the physicians and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

X _____ Date: _____
Signature of Patient (If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.

Parent/Guardian Name (Print) _____ Relationship to Patient _____

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

- I acknowledge that I was provided with the Notice of Privacy Practices of Children's Heart Center (CHC).
- I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information (PHI) as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time to time (HIPAA), may be left for me on voicemail systems, answering machines or email addresses at the following telephone numbers and email addresses, in addition to any other numbers provided to you by me:

Telephone (____) ____-____ Home Office Cell* Other _____
Telephone (____) ____-____ Home Office Cell* Other _____
Telephone (____) ____-____ Home Office Cell* Other _____
Email _____ Home Office Other _____
Email _____ Home Office Other _____
Email _____ Home Office Other _____

* Text By checking this box, I authorize CHC to text the provided number (Standard Text Messaging Rates Apply)
Please provide name of your carrier AT&T Cricket Nextel Sprint T Mobile Verizon Other

- I agree that my PHI may be shared with my
 Mother Please provide full name _____
 Father Please provide full name _____
 SPOUSE Please provide full name _____

- I agree that my PHI may be shared with the following individuals and/or agencies:

By checking this box, I authorize CHC to release my demographic information to Children's Heart Foundation, a nonprofit organization in Nevada which benefits children who have or develop a heart problem. www.chfn.org

X _____ Date: _____
Signature of Patient (If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.

Parent/Guardian Name (Print) _____ Relationship to Patient _____

PHARMACY PREFERENCE

Prescriptions are sent electronically to the pharmacy of your choice. Please provide the appropriate information.
Pharmacy Name _____ Phone Number _____
Address: _____ City: _____ State: _____ Zip: _____