Childrens Heart Center Nevada all hearts
continuous care for the fetus, child & adult with congenital heart disease

# WELCOME TO OUR PRACTICE!

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

## PATIENT INFORMATION

**Name:** _____ (Last / First / MI) **Date of Birth** _____ ❒ Check if minor (less than 18) **Gender:** ❒ M ❒ F

**Soc. Sec.#**_____ **Driver's License #** _____ **Marital Status:** ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ X-Separated

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

**Race/Ethnicity:** ❒ **C**-Caucasian ❒ **B**-Black ❒ **H**-Hispanic/Latin ❒ **A**-Asian ❒ **G**-Native American ❒ **P**-Pacific Islander ❒ **F**-Asian Pacific American
❒ **D**-Subcontinent Asian American ❒ **I**-American Indian/Alaskan Native ❒ **J**-Native Hawaiian ❒ **N**-Black Non-Hispanic ❒ **O**-White Non-Hispanic ❒ **E**-Other

**1st Language:** ❒English ❒Spanish ❒ Other_____ **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

**Name:** _____ (Last / First / MI) **Date of Birth** _____ **Gender:** ❒M ❒F **Soc. Sec.#**_____

**Relationship to Patient:** ❒Mother ❒Father ❒Foster ❒Other_____ **Marital Status:** ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ X-Separated

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

**Race/Ethnicity:** ❒ **C**-Caucasian ❒ **B**-Black ❒ **H**-Hispanic/Latin ❒ **A**-Asian ❒ **G**-Native American ❒ **P**-Pacific Islander ❒ **F**-Asian Pacific American
❒ **D**-Subcontinent Asian American ❒ **I**-American Indian/Alaskan Native ❒ **J**-Native Hawaiian ❒ **N**-Black Non-Hispanic ❒ **O**-White Non-Hispanic ❒ **E**-Other

**Driver's License #** _____ **1st Language:** ❒English ❒Spanish ❒ Other_____ **2nd Language:** ❒English ❒Spanish ❒ Other_____

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

**Employer:** _____ **Work Phone:** _____

**Employer Address:** _____ **Work Hours:** _____

## OTHER PARENT OR GUARDIAN INFORMATION

**Name:** _____ (Last / First / MI) **Date of Birth** _____ **Gender:** ❒M ❒F **Soc. Sec.#**_____

**Relationship to Patient:** ❒Mother ❒Father ❒Foster ❒Other_____ **Marital Status:** ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ X-Separated

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

**Race/Ethnicity:** ❒ **C**-Caucasian ❒ **B**-Black ❒ **H**-Hispanic/Latin ❒ **A**-Asian ❒ **G**-Native American ❒ **P**-Pacific Islander ❒ **F**-Asian Pacific American
❒ **D**-Subcontinent Asian American ❒ **I**-American Indian/Alaskan Native ❒ **J**-Native Hawaiian ❒ **N**-Black Non-Hispanic ❒ **O**-White Non-Hispanic ❒ **E**-Other

**Driver's License #** _____ **1st Language:** ❒English ❒Spanish ❒ Other_____ **2nd Language:** ❒English ❒Spanish ❒ Other_____

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

**Employer:** _____ **Work Phone:** _____

**Employer Address:** _____ **Work Hours:** _____

## 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.

## EMERGENCY CONTACT INFORMATION

**Name of Closest Relative Not Living With You:** _____

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

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

## 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:**

Name_____ Relationship _____ Name_____ Relationship _____

Name_____ Relationship _____ Name_____ Relationship _____

Name_____ Relationship _____ Name_____ Relationship _____

Name_____ Relationship _____ Name_____ Relationship _____

❒ **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:** _____