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

New Patient Registration Form

PATIENT INFORMATION

Patient Name: | **DOB:** | **Marital Status:** ❒S ❒M ❒Other

Gender at Birth: ❒Male ❒Female **Gender Identity:** ❒Male ❒Female ❒Transgender Male ❒Transgender Female ❒Genderqueer ❒Other _____ ❒Prefer not to answer

Soc. Security # | **Email:** | **Phone:**

Address: | **City:** | **State:** | **Zip:**

Race: ❒Caucasian/White ❒African American/Black ❒Asian ❒Native American/Pacific Islander ❒American Indian/Alaska Native **Ethnicity:** ❒Latino/Hispanic ❒NOT Latino/Hispanic ❒Other _____

Primary Language Spoken: _____

Employer: | **Employer Phone:**

Primary Care Physician: | **Primary Care Phone:**

Referring Physician: | **Referring Physician Phone:**

SPOUSE/PARENT OR GUARDIAN INFORMATION

Name: | **Gender:** ❒M ❒F ❒Other | **DOB:** | **Marital Status:** ❒S ❒M ❒Other

Soc. Security # | **Email:** | **Phone:**

Address: | **City:** | **State:** | **Zip:**

Relationship to Patient: ❒Mother ❒Father ❒Foster ❒Other_____

Primary Language Spoken: _____

Employer: | **Employer Phone:**

OTHER PARENT OR GUARDIAN INFORMATION

Name: | **Gender:** ❒M ❒F ❒Other | **DOB:** | **Marital Status:** ❒S ❒M ❒Other

Soc. Security # | **Email:** | **Phone:**

Address: | **City:** | **State:** | **Zip:**

Relationship to Patient: ❒Mother ❒Father ❒Foster ❒Other_____

Primary Language Spoken: _____

Employer: | **Employer Phone:**

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:** _____

INSURANCE INFORMATION

Primary Insurance Company: _____ **Plan Phone:** _____
Name of Policyholder: _____ **Policyholder's DOB:** _____
Patient Relationship: ❒Self ❒Child ❒Stepchild ❒Spouse ❒Other _____

Policy ID# _____ **Group #** _____

Secondary Insurance Company: _____ **Plan Phone:** _____
Name of Policyholder: _____ **Policyholder's DOB:** _____
Patient Relationship: ❒Self ❒Child ❒Stepchild ❒Spouse ❒Other _____
Policy ID# _____ **Group #** _____

Tertiary Insurance Company: _____ **Plan Phone:** _____
Name of Policyholder: _____ **Policyholder's DOB:** _____
Patient Relationship: ❒Self ❒Child ❒Stepchild ❒Spouse ❒Other _____
Policy ID# _____ **Group #** _____

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 physicians 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_____
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** _____

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

• I acknowledge that the Notice of Privacy Practices of Children's Heart Center (CHC) is available upon request.

• 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 _____

Email _____❒ Home ❒ Office ❒ 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) _____

❒ 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** _____