

Patient #: \_\_\_\_\_ **PATIENT RECORD** Date: \_\_\_\_\_

**PLEASE PRINT SIBLEY HEART CENTER CARDIOLOGY**

Patient Last Name: \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Patient Social Security: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

GUARANTOR'S MARTIAL STATUS: Married: \_\_\_\_\_ Single: \_\_\_\_\_ Divorced: \_\_\_\_\_ Separated: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address (If different above): \_\_\_\_\_ Address (If different above): \_\_\_\_\_

Zip \_\_\_\_\_ Zip \_\_\_\_\_

Social Security#: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security#: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

If not the parent, who is bring the child in today? \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Employer: \_\_\_\_\_

Reason for Visit (Diagnosis) \_\_\_\_\_

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_

Address: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Sex \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient/Sub Relationship \_\_\_\_\_

Employer: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group# \_\_\_\_\_

**DO YOU HAVE OTHER INSURANCE? YES \_\_\_\_\_ NO \_\_\_\_\_ IS THE CHILD COVERED BY ANY OTHER INSURANCE? YES \_\_\_\_\_ NO \_\_\_\_\_**

**SECONDARY INSURANCE COMPANY** \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Sex \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient/Sub Relationship \_\_\_\_\_

Employer: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group# \_\_\_\_\_

**PEDIATRICIAN FAMILY MD** \_\_\_\_\_

Address: \_\_\_\_\_

Suite \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Which physician are you seeing today? \_\_\_\_\_

ALL CHARGES ARE DUE AT THE TIME OF SERVICE UNLESS IN-PATIENT HOSPITAL CHARGES

- I hereby authorize the above physician or hospital to obtain records from other sources as may be needed in the treatment of this patient.
  - I hereby authorize the Release of Information concerning this patient's treatment to other physicians involved in the care and treatment of this patient.
  - I hereby authorize the Release of Information to the insurance company as needed to file for charges incurred by this patient.
- I hereby authorize payment of insurance benefits otherwise due to me to be made directly to the above physician or hospital. I understand that I am responsible for any amount not covered by the insurance company.
- A copy of this information shall be as valid as the original.

Signature of Parent or Responsible Party \_\_\_\_\_

Date \_\_\_\_\_