CARDIOLOGY SPECIALISTS
of Orange County

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

OTHER (WRITE IN NAME OF INSURANCE COMPANY) ☐	MAILING ADDRESS	POLICY #

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MEDICARE (PLEASE GIVE NUMBER) ☐	RAILROAD RETIREMENT (PLEASE GIVE NUMBER)

INDUSTRIAL ☐	WERE YOU INJURED ON THE JOB? ☐ ☐	DATE OF INJURY	INDUSTRIAL CLAIM #

ACCIDENT ☐	WAS AN AUTOMOBILE INVOLVED ☐ ☐	DATE OF ACCIDENT	NAME OF ATTORNEY

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** _____