PLEASE PRINT CLEARLY

PATIENT INFORMATION

LAST NAME OF PATIENT	FIRST	MI	MARITALSTATUS ☐S ☐M ☐D	ADDRESS		
CITY	STATE	ZIP CODE	SEX	HOME PHONE ( ) -	WORK PHONE ( ) -	DATE OF BIRTH / /
SOCIAL SECURITY NO. --- ---	DRIVERS LICENSE NO.			DAYTIME PHONE/CELL		AGE OF PATIENT
IS RESPONSIBLE PARTY THE PATIENT? ☐ YES ☐ NO	IF NOT - RESPONSIBLE PARTY'S NAME:			HAS RESPONSIBLE PARTY BEEN A PATIENT BEFORE? ☐ YES ☐ NO		TELEPHONE ( ) -
EMPLOYED BY	YEARS	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE ( ) -

RESPONSIBLE PARTY STATEMENT

"As The Responsible Party, I Agree That All Charges That Are Not Directly Paid By My Insurance Company Will Be My Responsibility."	RESPONSIBLE PARTY SIGNATURE	TODAY'S DATE / /

REFERRED BY DR:

DOCTOR'S LAST NAME	TELEPHONE ( ) -

IN CASE OF EMERGENCY NOTIFY (OTHER THAN SPOUSE)

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE ( ) -

SPOUSE INFORMATION

SPOUSE LAST NAME (IF DIFFERENT)	FIRST NAME		MI	MARITAL STATUS ☐ SING. ☐ MAR. ☐ DIV.
DATE OF BIRTH / /	SEX	RELATIONSHIP SOCIAL SECURITY NO. --- ---	IS THIS SPOUSE THE PATIENT ? ☐ YES ☐ NO	
EMPLOYED BY			TELEPHONE ( ) -	
ADDRESS OF EMPLOYER				

INSURANCE COMPANY INFORMATION

NAME OF PRIMARY INSURANCE COMPANY			GROUP NO.	NAME OF SECONDARY INSURANCE COMPANY			GROUP NO.
ADDRESS			I. D. NO.	ADDRESS			I. D. NO.
CITY	STATE	ZIP	TELEPHONE ( ) -	CITY	STATE	ZIP	TELEPHONE ( ) -
NAME & ADDRESS OF INSURED IF THE RESPONSIBLE PARTY IS NOT THE INSURED						SEX	RELATIONSHIP TO PATIENT

REASON FOR TODAY'S VISIT OR CHIEF COMPLAINT:

PAYMENT OF BENEFITS

I authorize the payment of benefits, as determined by the Company, directly to

Northwest Heart Center ☐ Yes ☐ No

I understand that unless I have checked "Yes" above, benefit payments will be paid to me. I also understand that even if I have checked "Yes" above, I may still be responsible for any amounts not paid by my Insurance Company in the event that the charges made are not reasonable and customary.

X	DATE / /

MEDICAL RELEASE INFORMATION

Insured party must sign for all claims. Dependent patient must sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that the information I furnish is true and correct.

I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

X	DATE / /
X	DATE / /