

**CHILDREN'S HEART SPECIALISTS, PSC
REGISTRATION FORM**

PATIENT'S NAME _____ DOB _____ SEX _____

PATIENT'S PRIMARY CARE PHYSICIAN

NAME _____ PHONE (INCLUDING AREA CODE) _____

LEGAL CUSTODIAN'S INFORMATION

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (INCLUDING AREA CODE) _____ CELL (INCLUDING AREA CODE) _____ WORK (INCLUDING AREA CODE) _____

EMPLOYER _____ SOCIAL SECURITY # _____ DOB _____

IF OTHER PARENT DOES NOT LIVE WITH PATIENT, PLEASE PROVIDE THAT INFORMATION

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (INCLUDING AREA CODE) _____ CELL (INCLUDING AREA CODE) _____ WORK (INCLUDING AREA CODE) _____

EMPLOYER _____ SOCIAL SECURITY # _____ DOB _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY AND FOR APPOINTMENT REMINDERS?

1. NAME _____ PHONE (INCLUDING AREA CODE) _____ RELATIONSHIP TO PATIENT _____

2. NAME _____ PHONE (INCLUDING AREA CODE) _____ RELATIONSHIP TO PATIENT _____

AUTHORIZED INDIVIDUAL

In the event of my absence, I authorize the following person to bring my child in for medical care:

NAME _____ PHONE (INCLUDING AREA CODE) _____ RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION — COPY OF CARD REQUIRED

PRIMARY INSURANCE COMPANY _____ POLICY HOLDER NAME _____

DOB _____ GROUP # _____ ID# _____

SECONDARY INSURANCE COMPANY _____ POLICY HOLDER _____

DOB _____ GROUP # _____ ID# _____

INSURANCE AUTHORIZATION, ASSIGNMENT & RELEASE OF INFORMATION

I authorize payment of medical insurance benefits to Children's Heart Specialists for services rendered. I understand that I am financially responsible for all charges, regardless of insurance coverage. I understand that I am responsible for obtaining any and all referrals required by my insurance or I will assume responsibility for all charges. If I receive a "Coordination of Benefits" request from my insurance company, I will complete the request within one week or I will assume responsibility for all charges. I understand that all balances must be paid in full by insurance and/or legal custodian of patient within 90 days from date of service, or be subject to a 10% interest charge.

I authorize the release/photocopy of patient's medical records from Children's Heart Specialists to any requesting physician or medical facility, government agency or insurance carrier.

I agree to the above and understand this authorization will remain in effect for four years.

LEGAL CUSTODIAN SIGNATURE _____

DATE _____

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