
# PATIENT REGISTRATION

**General**

**Name** _____
**Last** **First** **Middle**

**Date of Birth**_____ **SS#**_____

**M/F** **Driver's License No.**_____**State**_____

**Marital Status** **Single**___ **Married** ___ **Widowed**____ **Divorced**____ **Other**_____

**Addresses**

**Home Address**_____
**Street Address** **City** **State** **Zip**

**Telephone numbers:**_____

**Employer Name**_____**Occupation**_____

**Work Address**_____
**Street Address** **City** **State** **Zip**

**Work Phone No.** _____**Email address**_____

**Emergency Contact**_____**Relationship**_____**Ph No.**_____

**Primary Insurance***

**Name of Insurance Co.**_____**Subscriber ID**_____

***If not you, put name, dob, SS# of subscriber and relationship on back of this form.**

**Secondary Insurance***

**Name of Insurance Co.**_____**Subscriber ID**_____

**Please sign and return to receptionist:**

**I, the undersigned, assign directly to Michael J. Wong, M.D. (HeartCare) all medical benefits payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.**

**Signature**_____**Date:**_____

**If Pt is a minor, signature of Parent or Guardian authorizing treatment.**

**If you would like to be a patient of HeartCare, please call us for an appointment. Then complete this form and the three-page History and either fax them back to us at 213 483-0735, or bring them with you when you come in.**