



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.

