WESTCHESTER MEDICAL GROUP CENTER FOR HEART AND HEALTH
PATIENT INFORMATION
Please print

Patient:_____ Social Security #:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email: _____

Sex: Male( ) Female ( ) Single ( ) Married ( ) Widowed ( ) Divorced ( )

Birthdate:_____ Driver's License:_____

Occupation:_____ Work phone: (_____)_____

Employed by:_____

Employer's address:_____

Name of Spouse or
Parent (if child):_____ Social Security #:_____

Occupation:_____ Work Phone: (_____)_____

Employed by:_____

Employer's address:_____

Important:
In an emergency notify:_____ Phone: (_____)_____

Referred

by:_____

INSURANCE INFORMATION

MEDICARE: (YES)____(NO)___ Number:_____

MEDI-CAL: (YES)____(NO)___ Number:_____

Primary Insurance:_____ Phone: (_____)_____

Secondary Insurance:_____ Phone: (_____)_____

(Please show your insurance identification card to the receptionist so that she can make a copy. If your insurance company requires that its own form be used for claims, please bring one with you on each visit.)

PATIENT AUTHORIZATION AND ASSIGNMENT

I hereby authorize Westchester Medical Group Center for Heart and Health to furnish my insurance company with all information concerning my illness or injury.

I hereby assign payment of all benefits to which I am entitled directly to Westchester Medical Group Center for Heart and Health for services rendered by Group physicians and/ or related medical expenses. (A photocopy of this authorization/ assignment may serve as the original.)

Signed:_____ Date:_____