California Heart associates
A Medical Group

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*Hoang P. Nguyen, MD*
*Nikhil P. Warrier, MD*
*Yu-Ming Ni, MD*
*Kerry Wood, NP-C*

ACCOUNT NO: _____

# PATIENT REGISTRATION FORM

| | | | |
|---|---|---|---|
| LAST NAME: | FIRST NAME: | MIDDLE INIT: | DATE OF BIRTH: |
| ADDRESS: | CITY: | STATE: | ZIP: |
| HOME PHONE: | CELL PHONE: | EMAIL: | |
| SOCIAL SECURITY NUMBER: | DRIVER LICENSE NO: | SEX(M/F): | MARITAL STATUS: |
| REFERRED BY: | PCP PROVIDER: | PCP TELEPHONE: | PCP FAX: |

RACE: ❑ White ❑ Asian ❑ Black/African American ❑ Native Hawaiian or Other Pacific Islander ❑ American Indian-Alaskan Native ❑ Other Race
ETHNICITY: ❑ Hispanic or Latino ❑ Non-Hispanic or Latino
PREFERRED LANGUAGE: ❑ English ❑ Other _____

## Primary Insurance

| | | | |
|---|---|---|---|
| INSURANCE COMPANY: | ID/POLICY NO; | GROUP NO: | EFFECTIVE DATE: |
| SUBSCRIBER'S NAME: | DATE OF SUBSCRIBER'S BIRTH: | SOCIAL SECURITY NO: | CO-PAY AMOUNT |
| MEDICAL GROUP / IPA | SUBSCRIBER'S RELATIONSHIP TO PATIENT | SUBSCRIBER'S TELEPHONE NO: | |

## Secondary Insurance

| | | | |
|---|---|---|---|
| INSURANCE COMPANY: | ID/POLICY NO: | GROUP NO: | EFFECTIVE DATE: |
| SUBSCRIBER'S NAME: | DATE OF SUBSCRIBER'S BIRTH: | SOCIAL SECURITY NO: | CO-PAY AMOUNT: |
| MEDICAL GROUP / IPA | SUBSCRIBER'S RELATIONSHIP TO PATIENT: | SUBSCRIBER'S TELEPHONE NO: | |

I hereby assign, transfer, and set over to California Heart Associates all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy, or workers compensation carrier, for services furnished by them. I understand that I am financially responsible for any balance not covered by my insurance.

X _____

SIGNATURE OF PATIENT DATE:

California Heart Associates, physicians and staff, are authorized to use the telephone message system to aid in communications with me, or my authorized representative(s), regarding my treatment, appointments, financial arrangements, and for any response I have initiated. (complete all that apply)

| | | |
|---|---|---|
| AUTHORIZED NAME / EMERGENCY CONTACT | RELATIONSHIP TO PATIENT: | AUTHORIZED PERSON'S TELEPHONE: |
| AUTHORIZED NAME: | RELATIONSHIP TO PATIENT: | AUTHORIZED PERSON'S TELEPHONE: |

X _____

SIGNATURE OF PATIENT DATE:

*Fountain Valley • 18111 Brookhurst St., Suite 5100 • Fountain Valley, CA 92708* *(714) 546-2238* *Fax (714) 434-8145*
*Fountain Valley • 18111 Brookhurst St., Suite 5800 • Fountain Valley, CA 92708* *(714) 432-7833* *Fax (714) 432-7830*
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