Comprehensive Cardiovascular
Leading the fight against heart disease
CCVMG

Comprehensive Cardiovascular
5945 Truxtun Avenue
Bakersfield, CA 93309-0610
(661) 323-4278

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)	ETHNICITY

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE	RACE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT
			$
CITY, STATE ZIP			DEDUCTIBLE
			$
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

1. I hereby assign the insurance benefit payment, both basic and major medical to which I am entitled, directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by the assignment. A photocopy of this authorization is accepted with the same authority as the original.
2. I hereby authorize the physician to release any information acquired in the course of my treatment to another physician of my choice, my insurance company, my attorney or to me at the above address within one (1) year of the date of this signature.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____