Golden Empire Cardiology

Patient Registration Form

Please Fill Completely. Please Print.

Today's Date _____ / _____ / _____ Date of Birth _____ / _____ / _____

Full Name **(First, Middle, Last)** _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Referring Doctor _____ SSN _____ Email _____

Sex: **Male** **Female**

Communication Preference: **Email** **Phone** **Mail**

Race: **White** **American Indian** **Alaskan Native** **Asian** **Native Hawaiian or Pacific Islander** **Black or African American**

Ethnic Group: **Hispanic or Latino** **NOT Hispanic or Latino**

Language _____

Employer **(If self employed, please put name of business)** _____

Work Phone _____ Primary Care Physician _____

Emergency Contact/Relationship _____ Emergency Phone _____

Primary Insurance _____

Secondary Insurance **(Only used if medicare is primary)** _____

Spouse/Guarantor (Required for Insurance Purpose)

Name _____

DOB _____ / _____ / _____ SSN _____

Street Address _____

City _____ State _____ Zip Code _____

Employer **(If self employed, please put name of business)** _____

Work Phone _____

Please have your Insurance card available at our front desk. Payment for services must be made at the time ser- vices rendered to avoid a surcharge of $15.00.

Release of Information & Assignments of Benefits Declaration

I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from my insurance for services rendered. I understand and agree to the above.

Date _____ / _____ / _____ Signature _____

3838 San Dimas St. Suite B 201 Bakersfield, CA 93301

P 661.321.3161 • F 661.321.3166
www.goldenempirecardiology.com