Imperial Cardiac Center
Imperial Valley Family Care Medical Group, APC

Patient Information Form

DOCTOR ____________________________ **DATE** ______________________________

PATIENT ACCT# ______________________

PATIENT INFORMATION **PLEASE PRINT**

LAST NAME		FIRST		MIDDLE	SEX ☐ M ☐ F
AGE	DATE OF BIRTH	STREET ADDRESS & MAILING ADDRESS (IF DIFFERENT)			APT. NO.
CITY		STATE	ZIP CODE	SOCIAL SECURITY NUMBER	
HOME PHONE	BUSINESS PHONE	MARITAL STATUS ☐ Single ☐ Married ☐ Separated			
PATIENT EMPLOYER / OCCUPATION			SPOUSE'S NAME		
PERSON TO NOTIFY (NAME & ADDRESS OF RELATIVE OR FRIEND NOT LIVING WITH YOU)				TELEPHONE NUMBER	
REFERRED BY	ADDRESS				

FINANCIAL RESPONSIBILITY

LAST NAME FIRST MIDDLE		SOCIAL SECURITY NUMBER		RELATIONSHIP TO PATIENT	
ADDRESS		CITY		STATE	ZIP CODE
HOME PHONE	BUSINESS PHONE	EMPLOYER	ADDRESS		
VISA CARD #	EXPIRATION	MASTERCARD #	EXPIRATION	SIGNATURE	

INSURANCE – PLEASE PRESENT INSURANCE CARD TO THE RECEPTIONIST WITH THIS FORM

NAME OF PRIMARY INSURANCE COMPANY		ADDRESS	
POLICY OR CERTIFICATE NUMBER	GROUP #	EFFECTIVE DATE	POLICYHOLDER'S NAME & DOB
NAME OF SECONDARY INSURANCE		ADDRESS	
POLICY OR CERTIFICATE NUMBER	GROUP #	EFFECTIVE DATE	POLICYHOLDER'S NAME & DOB

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS AND TO MY INSURANCE COMPANY, IF APPLICABLE.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY THE PHYSICIAN AND AUTHORIZE TRANSFER OF ALL UNPAID AMOUNTS TO MY VISA/MASTERCARD AFTER 120 DAYS FROM THE DATE OF SERVICE.

I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT.

I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO IMPERIAL VALLEY FAMILY CARE MEDICAL GROUP, APC.

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SIGNATURE **DATE**