GLENDALE HEART INSTITUTE MEDICAL GROUP
PATIENT INFORMATION

Referred by:_____Chief complaint for visit:_____

Name_____
Last First
Initial

Street Address_____

City_____State_____ Zip _____

Sex: Male_____ Female_____Age:_____Employer or
Retired:_____

Occupation:_____Married Single Divorced Widowed Partnered

Home Phone# (_____)_____ Bus/2nd Phone#(_____)_____
Area Code Area Code
Date of Birth_____ Social Security #_____

Whom may we contact in case of an emergency:_____
Name

_____ _____
_____
Telephone Number Relationship

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INSURANCE INFORMATION

Primary Insurance Company name:_____

Insurance Address:_____
Policy #:_____Group #_____

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FINANCIAL POLICY and **RELEASE OF MEDICAL RECORDS**

I certify that I have insurance coverage with_____and assign directly to GIMC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I understand the medical services rendered by Glendale Internal Medicine and Cardiology Medical Group are provided directly to me, not to my insurance company. If my insurance company fails to make payment or denies the claim, I am responsible for all fees incurred. I authorize any medical records pertaining to my diagnosis, treatment, prognosis and recommendations be released to my insurance company in order to obtain payment for services rendered.

_____ _____
Date Signature

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MEDICARE /MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and if applicable, Medigap benefits, be made either to me or on my behalf to Glendale Internal Medicine and Cardiology for any services furnished to me by the provider. To the extent permitted by law, I authorize any holder of medical or other information about me to be released to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Date Signature