❒ New Patient | CHILDREN'S HEART INSTITUTE | Clinic: Herndon

❒ Existing/Update | Adult Patient Registration

Welcome to our Practice. Please complete the information below.

Patient's Full Name (First – Middle – Last)	Sex: M [ ] F [ ]	Patient's Birth Date _____/_____/______ Age__________	Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence Address City State Zip		Home Phone:	Patient's Social Security #
Pharmacy: Phone:		Fax:	Email:
Name of Employer Address		Business Phone	Occupation
Name of Spouse / Parent	Birth date	Business Phone	Social Security # (SSN)
Reason for Visit	Primary Care Physician: Phone:		
Person to contact in case of emergency	Relationship to patient	Phone	

Primary Insurance Company	Policy ID #	Group / Plan #	Effective Date(s)
Is insurance through your employer? [ ] Yes [ ] No	Insurance Claims Address	Provider Phone Number	
Subscriber Name – Policy Holder	Policy Holder Birth Date	Policy Holder SSN	Relationship to Patient

Secondary Insurance Company	Policy ID #	Group / Plan #	Effective Date(s)
Is insurance through your employer? [ ] Yes [ ] No	Insurance Claims Address	Provider Phone number	
Subscriber Name – Policy Holder	Policy Holder Birth Date	Policy Holder SSN	Relationship to Patient

Private Insurance Authorization for Assignment of Benefits and Information Release: I, the undersigned, authorize payment of medical benefits to **CHC** for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

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Patient / Parent or Guardian Signature Date