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CEO / FAMILY NURSE PRACTITIONER

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PATIENT INFORMATION

LAST	FIRST	MIDDLE	
SOCIAL SECURITY NUMBER	BIRTH DATE	❑ MALE ❑ FEMALE	APT. NUMBER
ADDRESS		CITY	STATE/ZIP
PHONE ( )	MARITAL STATUS ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Single	EMPLOYER NAME	
EMPLOYER ADDRESS	CITY	STATE/ZIP	WORK PHONE ( )

GUARANTOR INFORMATION (head of household to receive billing statements, if any)

LAST	FIRST	MIDDLE	
SOCIAL SECURITY NUMBER	BIRTH DATE	❑ MALE ❑ FEMALE	APT. NUMBER
ADDRESS		CITY	STATE/ZIP
PHONE ( )	MARITAL STATUS ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Single	EMPLOYER NAME	
EMPLOYER ADDRESS	CITY	STATE/ZIP	WORK PHONE ( )

PATIENT'S RELATIONSHIP TO GUARANTOR: ❑ Self ❑ Spouse ❑ Son ❑ Daughter ❑ Other

INSURANCE INFORMATION (Please provide copy of insurance card)

PRIMARY INSURANCE INFORMATION

SUBSCRIBER (Policyholder):	LAST	FIRST	MIDDLE
INSURANCE COMPANY NAME	SUBSCRIBER EMPLOYER NAME		
POLICY EFFECTIVE DATE	SUBSCRIBER ID NUMBER	GROUP NUMBER	BIRTH DATE
INSURED (Patient) ID NUMBER	INSURED (Patient) PCP	PATIENT'S RELATIONSHIP TO SUBSCRIBER: ❑ Self ❑ Spouse ❑ Son ❑ Daughter ❑ Other	

SECONDARY INSURANCE INFORMATION

SUBSCRIBER (Policyholder):	LAST	FIRST	MIDDLE
INSURANCE COMPANY NAME	SUBSCRIBER EMPLOYER NAME		
POLICY EFFECTIVE DATE	SUBSCRIBER ID NUMBER	GROUP NUMBER	BIRTH DATE
INSURED (Patient) ID NUMBER	INSURED (Patient) PCP	PATIENT'S RELATIONSHIP TO SUBSCRIBER: ❑ Self ❑ Spouse ❑ Son ❑ Daughter ❑ Other	

EMERGENCY CONTACT / OTHER INFORMATION

NAME	RELATIONSHIP		
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE ( )	WORK PHONE ( )		

Other than to yourself, to whom may we release test results: Name____________________________ Relationship____________________________

I hereby authorize payment directly to Straight From The Heart Medical Professionals for surgical and/or medical benefits, if any, otherwise paid to me for unpaid services rendered and the release of any information necessary to process claims for said services and authorization to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan, via voice, electronic, mail or fax transmission. I also agree to pay all charges and/or co-payments at the time of service. In the event of default, I promise to pay all legal fees, collection costs, and/or interest as may be required to effect collection of this note. This will also serve as an authorization for release of emergency department, urgent care and/or medical records which may be necessary in my medical care.

Signed:____ Date:____________________
(Patient or Responsible Party)