



windwardheart
center LLC

2010 Patient Registration Form

Referring or Primary Care Physician _____

Patient Name _____

Date of Birth _____

Gender

Female

Male

SSN# _____

Drivers License # _____

Address _____

Email _____

Home Phone _____

Cell Phone _____

Work Phone _____

How would you like to be reached? _____

Billing Address (if different from above) _____

Guarantor Name (if different from above) _____

Address _____

Ethnicity (please circle) Asian / White / Hawaiian / African American / Pacific Islander / Other

Marital Status

Single

Married

Divorced

Seperated

Widowed

Employment Status

FT

PT

Retired

Active Duty

Self Employed

Not Employed

Student

Name of Employer or School _____

Work Phone _____

This visit is related to work injury or no fault automobile injury?

Yes

No

Date of Injury _____

Do you have an Advanced HealthCare Directive*?

Yes

No

Spouse or Next of Kin _____

Relationship _____

Phone _____

Address _____

* Advanced HealthCare Directives are specific instructions, prepared in advance, intended to direct a person's medical care in the event that he/she is unable to do so in the future.



I authorize the release of confidential medical information to the following contact persons

| | |
|--------------|--------------|
| Name | Name |
| Relationship | Relationship |
| Phone | Phone |

Insurance

| | |
|--|--|
| Primary Insurance | Secondary Insurance |
| Subscriber | Subscriber |
| Date of Birth | Date of Birth |
| Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Relation to Subscriber | Relation to Subscriber |

Emergency Contact

| |
|---------------------|
| Name |
| Relation to Patient |
| Phone |

Authorization for treatment, release of information, assignment of benefits and acknowledgement of responsibility for payment for physician services.

I hereby give my consent to Windward Heart Center LLC, Sonny J.H. Wong, M.D., F.A.C.C. and Maria Markarian, D.O.,F.A.C.C, to provide whatever treatment is deemed necessary.

I authorize any holder of medical information to release to my insurer and its agents, physicians, hospitals and other medical providers any information needed to determine benefits payable for these and related services.

I request that payment of authorized Medicare and other insurance benefits be made to me or on my behalf to Windward Heart Center LLC, Sonny J.H. Wong, M.D., F.A.C.C. and Maria Markarian, D.O.,F.A.C.C, for any services furnished. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges incurred, including any no show or late cancellation fees, and, in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection cost, in the event my account becomes delinquent.

| |
|--|
| Signature |
| Relationship to patient (if other than self) |
| Date |