Fit Heart MD

14411 Hamlin St., Van Nuys, CA. 91401

Patient Confidential Data Sheet

Last Name: _____

First Name: _____

Date of Birth: _____ Sex: Male / Female

Soc. Security #: _____

Driver's Lic. #: _____

Street Address: _____

City/State/ZIP: _____

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Pref. Language: _____

Ethnicity: _____ Hispanic or Latino

_____ Not Hispanic or Latino

Race: _____ American Indian or Alaska Native

_____ Asian

_____ Black or African-American

_____ Native Hawaiian or Other Pacific Islander

_____ White or Caucasian

Person to Notify in Case of Emergency

Name: _____

Relation to pt.: _____

Address: _____

City/State/ZIP: _____

Phone #: _____

Primary Insurance

Name: _____

Member ID #: _____

Group #: _____

Secondary Insurance

Name: _____

Member ID #: _____

Group #: _____

Employer's Name: _____

Employer's Address: _____

Ref. Doctor or PMD: _____

Pharmacy Name: _____

Pharmacy Phone #: _____

Allergies to Medication: _____

_____

I authorize you to give me reasonable and proper medical care by today's standards.

Payment is due at time services are rendered.

In case of non-payment by my insurance carrier, I will be responsible for payment in full.

I hereby authorize my insurance company to pay by check made out and mailed directly to:

Fit Heart MD

PO Box 3146

Chatsworth, CA. 91343-3146

I have received a copy of the Billing/Collection Policy of Fit Heart MD Practice.

Patient Signature: _____

Today's Date: _____