HEALTHY HEARTBEAT, PC

CENTER FOR HEART DISEASE, ARRHYTHMIAS, & PACING

PATIENT INFORMATION

NAME: _____ DATE: _____/_____/_____
SEX: MALE: _____ FEMALE: _____ BIRTHDAY: _____/_____/_____ AGE: _____
SOCIAL SECURITY #: _____/_____/_____ RACE: _____
MARITAL STATUS: MARRIED _____SINGLE _____ DIVORCED _____ WIDOWED_____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
EMAIL ADDRESS: _____
HOME PHONE: (_____) _____ CELL PHONE: (_____) _____
WORK PHONE: (_____) _____ EMPLOYER: _____
BEST WAY TO CONTACT YOU: HOME: _____ CELL: _____ WORK: _____
REFERRING PHYSICIAN: _____ PHONE #: (_____) _____
PRIMARY CARE PHYSICIAN: _____ PHONE #: (_____) _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE: _____ CARDHOLDER'S NAME: _____
POLICY ID NUMBER: _____ GROUP NUMBER: _____
CARDHOLDER'S DOB: _____/_____/_____ RELATION: _____

NAME OF SECONDARY INSURANCE: _____ CARDHOLDER'S NAME: _____
POLICY ID NUMBER: _____ GROUP NUMBER: _____
CARDHOLDER'S DOB: _____/_____/_____ RELATION: _____

EMERGENCY CONTACT

NAME: _____ PHONE: (_____) _____ RELATION: _____
NAME: _____ PHONE: (_____) _____ RELATION: _____

I HEREBY AUTHORIZE THE REELASE OF ANY MEDICAL INFORMATION NECESSARY FOR THE PROCESSING OF INSURANCE. I HEREBY ASSIGN MEDICAL AND/OR SURGICAL BENEFITS TO INCLUDE MAJOR BENEFITS TO WHICH I AM ENTITLED TO PAVEL RIHA, MD. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I HEREBY AUTHORIZE HEALTHY HEARTBEAT, PC TO ACCESS MY MEDICATION HISTORY WITHOUT LIMITATIONS OR EXCLUSIONS AS IS REQUIRED AND/OR REASONABLY ADVISABLE TO DISCLOSE, PROCESS, RETRIEVE, TRANSMIT, AND VIEW FOR THE PURPOSE OF THE TRANSMISSION OF AN ELECTRONIC PRESCRIPTION ISSUED BY A PROVIDER AUTHORIZED BY LAW TO PRESCRIBE, AS NECESSARY FOR MY CARE AND TREATMENT.

INSURED PATIENT: _____ DATE: ____/____/____

1226 N SHARTEL, SUITE 300, OKLAHOMA CITY, OKLAHOMA 73103
TEL; 405.231.8882 TOLL FREE: 1.877.RIHA.911 FAX: 405.231.8884 healthyheartbeat.com