



Patient Registration Information

The following information is required prior to receiving an appointment as a new patient in the Cardiovascular Clinic. Please do not hesitate to call us directly with any questions, or to register by phone at 650.736.1384.

Patient Information

Legal Name: _____

Patient A.K.A. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alt. Phone: _____ Work Phone: _____

Married Status: _____ Spouse's Name: _____

Language: _____ Interpreter Needed? Yes No

Social Security No.: _____ - _____ - _____ Date of Birth _____

Employment Information

Employment Status (Circle One): Full-Time Part-Time Self-Employed Retired

Employers Name: _____

Employers Phone Number: _____

Emergency Contact Information

Emergency Contact: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Work Phone: _____ Alt. Phone: _____

Insurance Information

Primary Insurance Co. Name: _____

Insurance Type (circle one): HMO PPO EPO POS Medi-Cal Medicare

Customer Service Phone No: _____

Member ID No: _____

Group No: _____

Issue Date: _____ (Necessary for Medi-Cal patients only)

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Relationship to Subscriber: _____

Referral/Authorization Information

Referring Physician Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Authorization No. (If Applicable): _____

➤ *Please mail a copy of the authorization for your visit or fax to 650.498.4531.*

Primary Care Physician

Physician or Nurse Practitioner Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____