DICRAN B. BARON, M.D., F.A.C.C.

CARDIOLOGY - ARRHYTHMIAS
705 W. LA VETA, SUITE 112
ORANGE, CA 92668

TODAY'S DATE

PATIENT REGISTRATION

PATIENT INFORMATION - PLEASE PRINT

NAME:	SEX:	BIRTH DATE:	AGE:
ADDRESS:	SOCIAL SECURITY NO.		
CITY: STATE: ZIP:	EMPLOYER:		
HOME PHONE: ( )	EMPLOYER ADDRESS:		
WORK PHONE: ( ) CELL: ( )	CITY: STATE: ZIP:		
REFERRING DOCTOR:	DRIVER'S LICENSE NO:		
NEAREST RELATIVE:	ADDRESS:		
RELATIVE PHONE: ( )	CITY: STATE: ZIP:		
MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED	INJURY? YES ☐ NO ☐	OCCUPATION:	
	DATE OF INJURY:	CHECK IF NO INSURANCE ☐	

PERSON RESPONSIBLE FOR PAYMENT (if other than patient)

NAME:	RELATION TO PATIENT	SOCIAL SECURITY NO.
ADDRESS:	OCCUPATION:	
CITY: STATE: ZIP:	EMPLOYER:	
HOME PHONE: ( )	EMPLOYER ADDRESS:	
WORK PHONE: ( )	CITY: STATE: ZIP:	
BIRTH DATE:	DRIVER'S LICENSE NO:	

INSURANCE INFORMATION - Please give all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply the information of both carriers.

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Carrier Name	Carrier Name
BILLING ADDRESS	BILLING ADDRESS
CITY: STATE: ZIP:	CITY: STATE: ZIP:
INSURED(name on ID card):	INSURED(name on ID card):
RELATION TO PATIENT: ☐ Self ☐ Spouse ☐ Child ☐ Other	RELATION TO PATIENT: ☐ Self ☐ Spouse ☐Child ☐ Other
INSURED'S ID NO:	INSURED'S ID NO:
GROUP NO:	GROUP NO:
COMPANY NAME:	COMPANY NAME:

ASSIGNMENT AND RELEASE: I hereby authorize payment of medical benefits directly to the physician and understand that fees not paid are my responsibility (this does not include any portion of the fee which is reduced by contractual agreement between the physician and my insurance company). The physician is further authorized to release any information necessary for the processing of this claim.

SIGNATURE:

_____**DATE**_____

\DOC\REGISTRATION