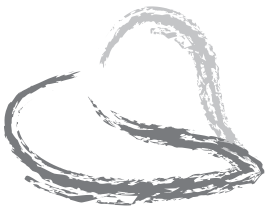

Interventional Cardiology Medical Group, Inc.

23101 Sherman Place • Suite 110 • West Hills, CA 91307
Phone (818) 702-8800 • Fax (818) 702-0080

Patient Demographics Form

Last Name | First Name | M.I. | Date of Birth (mm/dd/yyyy) | Age (yrs)

Home Address | City | State | ZIP

Social Security No. | Drivers License or State ID | Marital Status

Occupation (Current or last) | Employer | Check if Retired | Year Retired

Work Address | City | State | ZIP

Primary Physician Name | Physician Address & Phone No. | Who may we thank for referring you (if not your primary MD)?

Home Phone | Cell Phone | Work Phone

Email | Preferred Method of Contact

May we leave messages for you containing your protected health information at your preferred method of contact?	Yes	No
Would you like to join our web portal for online access to your health records, and physician messages?	Yes	No
Would you like to receive paperless statements?	Yes	No

Emergency Contact Name | Relationship | Cell Phone | Home/Work Phone

Do you have an Advance Directive/Living Will? | Are you an Organ Donor?

Insurance and Payment Responsibility Information and Agreement

Please complete this section AND bring your insurance card(s) with you for our records.

Check if Medicare _____ Check if you do not have insurance or intend to pay in cash _____

Insurance Company: _____

By my signature below, I hereby acknowledge the following:

1. The above information is true and correct to the best of my knowledge.
2. I am financially responsible for all charges whether or not paid by my insurance company subject to limits of the law.
3. I am responsible to know whether or not ICMG is contracted with my insurance company.
4. ICMG may release any information in its possession required to process my claims.
5. HMO patients: Service may not be rendered without authorization.
6. PPO and POS patients: I may wish to verify with my insurance company whether services rendered by ICMG are covered benefits.
7. A copy of the HIPAA Notice of Privacy Practices and acceptable e-mail use policy has been given to me and may be found at www.icardiomg.com.
8. Some requested services (such as filling out forms, etc) may incur a fee for which I will be directly responsible.

Your signature: (or authorized representative signature) **Date:**