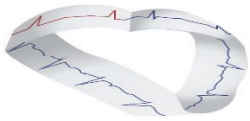

Berkeley Cardiovascular MEDICAL GROUP

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NAME (LAST,FIRST, MIDDLE)		MRN	BIRTHDATE	LANGUAGE	SEX
ADDRESS	CITY,STATE,ZIP		REFERRING PHYSICIAN		ETHNICITY
HOME PHONE	CELL/ DAY PHONE		EMAIL ADDRESS	PRIMARY CARE	RACE
MARITAL STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		EMERGENCY CONTACT PH #
PRIMARY EMPLOYER					
ADDRESS	CITY, STATE, ZIP		WORK PHONE		

NAME (LAST,FIRST, MIDDLE)	BIRTHDATE	LANGUAGE	SEX
ADDRESS	CITY,STATE,ZIP		
HOME PHONE	CELL/ DAY PHONE	EMAIL ADDRESS	
RELATIONSHIP TO PATIENT	MARITAL STATUS		

NAME OF INSURANCE COMPANY	POLICY #		GROUP #
NAME OF INSURED		COPAY	EFFECTIVE DATE
ADDRESS OF INSURANCE COMPANY	CITY, STATE, ZIP	PHONE #	RELATIONSHIP TO PATIENT

NAME OF INSURANCE COMPANY	POLICY #		GROUP #
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I authorize Berkeley Cardiovascular Medical Group to release any/all medical information acquired in the course of my medical treatment to my insurance co. or its agents. I request the payment of insurance benefits be made directly to Berkeley Cardiovascular Med Grp for services rendered. I understand I may be responsible for any charges not paid by my insurance co. I understand it is my responsibility to obtain proper authorization referral and confirm that Berkeley Cardiovascular and its physicians are participating with my insurance plan prior to services being rendered.

_____ SIGNATURE OF PATIENT/GUARDIAN

_____ DATE