Pediatric Cardiology Specialists

A Medical

Mohammad Kanakriyeh. M.D.

PATIENT REGISTRATION

Patient's Name (L, F M)
Nombre del Paciente

Date of Birth:
Fecha de Nacimiento:

Sex: ☐ M ☐ F
Sexso:

Address:
Domicilio:

City:
Ciudad:

State:
Estado:

Zip:
Zona Postal:

Home Telephone: ( ) -
Telefono de la casa:

Work Phone: Mom: ( ) -
Telefono Del Trabajo: Dad: ( ) -

Social Security
– –

Mother's Name:
Nombre de La Madre:

DOB/NAC:
/ /

Employer /Empleador

SS#
– –

Father's Name:
Nombre de Padre:

DOB/NAC:
/ /

Employer /Empleador

SS#
– –

Legal Guardian:

DOB/NAC:
/ /

Employer /Empleador

SS#
– –

Emergency Contact:
Contactado de Emergencia:

Address:
Domicilio:

Telephone:
Telefono:

Mother's Email:
Email de LaMadre:

Father's Email:
Email de Padre:

Legal Guardian
Email:

Insurance information

Primary Insurance:
Aseguranza Primordial:

Subscriber:
Suscritor Princpal:

ID#:

Address:
Domicilio:

Telephone:
( ) -

Authorization#:
Effective Date:

Secondary Insurance:
Aseguranza Secundaria:

Subscriber:
Suscritor Principal:

ID#:

Address:
Direccion:

Telephone:
( ) -

Authorization#:
Effective Date:

Medical: Medical#

CCS
County ?

CCS Case #

Referring MD:
Doctor Primordial:

Telephone:
( ) -

Medical Group:

Assignment of Benefits

I hereby authorize direct payment of medical benefits to Dr. Kanakriyeh for services rendered by him or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Release of Medical Information

I hereby authorize Dr. Kanakriyeh, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of this assignment shall be valid as the

Asignacion de Beneficios

Yo authorizo pago directo de beneficios medicos al Dr. Kanakriyeh por servicios rendidos por e'l o toddos bajo su supervision. Yo tengo entendido quesoy responsable de pagar cualquir ballance no pagado por mi seguro.

Salida de Informacion Medica

Yo authorizo Dr. Kanakriyeh a entregar cuaquier informacion medico or incidental que sea necessario por cuidado medico o en la processesacion de applicaciones for beneficios financiales

Signature: .....

Date: .....

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