CARDIOVASCULAR CONSULTANTS OF KANSAS, INC.

9350 E. 35th St. N., Suite 101 - Wichita, KS 67226
(316) 265-1308 - 1-800-362-1093 toll free

PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME	FIRST	M.I.	DATE
STREET ADDRESS		APARTMENT / UNIT #	
CITY	STATE	ZIP	
PHONE HOME / PHONE CELL	E-MAIL ADDRESS		
BIRTH DATE / SS#	❑ MALE ❑ FEMALE	MARITAL STATUS	
RACE	PREFERRED LANGUAGE		

ETHNICITY: ❑ LATINO/HISPANIC ❑ NON-LATINO/HISPANIC ❑ OTHER ❑ NOT REPORTED/REFUSED

ADVANCE DIRECTIVE OR LIVING WILL? ❑ YES ❑ NO	PATIENTS LEGAL GUARDIAN OR HEALTHCARE PROXY? ❑ YES ❑ NO	VETERAN? ❑ YES ❑ NO

EMPLOYER	PHONE
EMPLOYER ADDRESS	
SPOUSE NAME	SPOUSE EMPLOYER
SPOUSE CELL PHONE	WORK PHONE

GUARANTOR / RESPONSIBLE PARTY INFORMATION

NAME	ADDRESS	
BIRTH DATE	SS#	PHONE
EMPLOYER	ADDRESS	
PHONE	RELATIONSHIP TO PATIENT	IS THIS PERSON THE INSURED? ❑ YES ❑ NO
EMERGENCY CONTACT	ADDRESS	PHONE
REFERRING PHYSICIAN		CITY
PRIMARY CARE PHYSICIAN (IF DIFFERENT)		

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY	ADDRESS	
PHONE NUMBER	SUBSCRIBERS NAME	
BIRTH DATE	SS#	PHONE
EMPLOYER	ADDRESS	
PHONE	GROUP#	MEMBER ID#

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY	ADDRESS	
PHONE NUMBER	SUBSCRIBERS NAME	
BIRTH DATE	SS#	PHONE
EMPLOYER	ADDRESS	
PHONE	GROUP#	MEMBER ID#

RELEASE OF MEDICAL INFORMATION

HEREBY AUTHORIZE CARDIOVASCULAR CONSULTANTS OF KANSAS, PA TO RELEASE MY MEDICAL INFORMATION TO:

AME	RELATIONSHIP TO PATIENT

KANSAS HEART HOSPITAL OWNERSHIP

he 2010 Health Care Act requires all patients to know that the Kansas Heart Hospital is partially owned by physicians who are members of :ardiovascular Consultants of Kansas (CC of K), our medical practice group.

ia Christi Medical Center owns 49% and CC of K physicians own less than 15%.

you would like further details, please contact Gerard Bieker, Business Manager of CC of K at 316-265-1308.

our signature acknowledges that you have been informed of the above information. Thank you for your compliance with this federally mandated ealthcare regulation.

ATIENT SIGNATURE **DATE**

RELEASE OF MEDICAL INFORMATION

.uthorization to pay benefits to physician: I hereby assign payment directly to Cardiovascular Consultants of Kansas for the medical benefits, if any, therwise payable to me for services described, but not to exceed my indebtedness to Cardiovascular Consultants of Kansas for those services.

ısurance Information Release Authorization: I hereby authorize Cardiovascular Consultants of Kansas to release any information acquired in the course of ıy examination or treatment to my insurance company and/or employer.

inancial Agreement: I understand I am responsible for all fees, regardless of insurance coverage. See separate financial Policy/Agreement.

lotice of Privacy Policy: By signing, I acknowledge I have received or was offered a copy of the Notice of Privacy Practices for Cardiovascular Consultants of :ansas, PA.

:X History: I understand and give consent to Cardiovascular Consultants of Kansas, PA. to access my prescription medication history from other providers and/ r pharmacies.

ATIENT NAME (PLEASE PRINT) **DATE**

IGNATURE OF PATIENT / PATIENT REPRESENTATIVE