Newport Harbor Cardiology, Inc.

601 Dover Drive, Suite 2, Newport Beach, CA 92663

Patient Demographic Information

Patient Name: _____ _____ ____
Last Name First Name M.I.

Date of Birth: _____ Gender: M ☐ F ☐

_____ _____ _____
Street Address City/State/Zip Phone Number

Patient(s) Reside(s) with: ☐ Both parents ☐ Mother ☐ Father ☐ Other _____
(Please describe, i.e. joint custody, grandparent/legal guardian)

Responsible Parent/Legal Guardian Information (indicate who is financially responsible for the patient's medical care):

Check this box if both parents share financial responsibility. ☐ Please note we may require copies of legal guardianship papers.

_____ _____ _____
Last First Relationship to patient

_____ _____ _____
Street Address, if different than patient City/State/Zip Date of Birth

_____ _____ _____ _____
Occupation Employer Email Driver's License

_____ _____
Home Phone Other Phone #

Additional Parent/Legal Guardian Information:

_____ _____ _____
Last First Relationship to patient

_____ _____ _____
Street Address, if different than patient City/State/Zip Date of Birth

_____ _____ _____ _____
Occupation Employer Email Driver's License

_____ _____
Home Phone # Other Phone #

Ethnicity: Please check all that apply (Optional)

☐ Hispanic or Latino ☐ Non- Hispanic ☐ Unknown ☐ Declined

Race: Please check all that apply (Optional)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander

☐ White ☐ Unknown ☐ Declined

Language: (other than English)_____

I certify that I have provided information that is true and correct to the best of my knowledge:

_____ _____ _____
Parent/Legal Guardian Signature Date Relationship to patient