



TEXAS INSTITUTE OF CARDIOLOGY, P.A.

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(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
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Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	Former name?	Social Security No:	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street address:	Home phone no: ()	Cell phone No: ()
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P.O. box:	City:	State:	ZIP Code:
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Occupation:	Employer:	Employer phone no.: ()
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Referring Physician:

Primary Care Physician:

INSURANCE INFORMATION

(Please give your insurance card and driver's license to the receptionist.)

Person responsible for bill:

Relationship:	Birth date:	Address (if different):	Home phone no.: ()
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Primary Insurance	Subscriber's name:	Group no.:	Policy no.:
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Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
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IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Texas Institute of Cardiology or insurance company to release any information required to process my claims.

Patient/Guardian signature:

Date: