

TEXAS INSTITUTE OF CARDIOLOGY, P.A.
Faisal Wahid, M.D. F.A.C.C., F.S.C.A.I.

4510 MEDICAL CENTER DRIVE,
SUITE 208
MCKINNEY, TEXAS 75069
PH: 214- 544-7555 FX: 214-544-7556

PATIENT INFORMATION:

NAME _____ SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PH: (____) _____ WORK PH: (____) _____ CELL # (____) _____

MARRIED SINGLE DIVORCED WIDOWED / MALE FEMALE

AGE _____ DATE OF BIRTH _____

EMPLOYER NAME _____ ADDRESS _____

FULL TIME PART TIME RETIRED STUDENT (FULL TIME / PART TIME)

REFERRING PHYSICIAN _____ PH: _____ CITY _____

PRIMARY CARE PHYSICIAN _____ PH: _____ CITY _____ FAX: _____

INSURED NAME:

NAME _____ RELATIONSHIP _____

SOCIAL SECURITY # _____ DATE OF BIRTH: _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

EMPLOYER NAME _____ ADDRESS _____

NOTIFY IN CASE OF AN EMERGENCY:

NAME _____ RELATIONSHIP _____

HOME PH _____ BUSINESS PH _____ CELL _____

NAME _____ RELATIONSHIP _____

HOME PH _____ BUSINESS PH _____ CELL _____

INSURANCE INFORMATION:

(COPIES OF INSURANCE CARDS AND DRIVERS LICENSE ARE REQUIRED)

PATIENT SIGNATURE _____

INDIVIDUAL RESPONSIBLE FOR PAYMENT:

NAME _____ RELATIONSHIP _____
ADDRESS _____ CITY _____ ST _____ ZIP _____
HOME PH: (____) _____ WK PH: (____) _____ CELL: (____) _____
EMPLOYER _____ SOCIAL SECURITY # _____

ASSIGNMENT OF BENEFITS:

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL OF ALL CHARGES THAT MAY INCLUDE: DEDUCTIBLE, CO-PAYMENT AND/OR CHARGES NOT COVERED BY THE INSURANCE COMPANY. I AUTHORIZE PAYMENT OF BENEFITS FROM MY INSURANCE TO BE PAID DIRECTLY TO FAISAL WAHID, M.D., F.A.C.C., F.S.C.A.I. I ALSO AUTHORIZE THE TEXAS INSTITUTE OF CARDIOLOGY / DR. FAISAL WAHID, M.D., F.A.C.C., F.S.C.A.I. TO RELEASE TO MY INSURANCE COMPANY ANY AND ALL INFORMATION NECESSARY FOR THE PROCESSING OF INSURANCE CLAIMS.

SIGNATURE _____

DATE: _____

PATIENT NAME (PLEASE PRINT)