TEXAS INSTITUTE OF CARDIOLOGY, P.A.

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(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?		Former name?	Social Security No:	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street address:	Home phone no:	Cell phone No:
	( )	( )

P.O. box:	City:	State:	ZIP Code:

Employer/Occupation:	Race:	Primary Language:

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.:
	/ /		( )

Primary Insurance	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

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:*