Heart of Texas Cardiology, PA

New Patient Forms

Please fill out completely or mark areas "N/A" if they do not apply

Please provide the Front Desk Receptionist with your Insurance (s) and Photo ID

Name (last, first. M.I.) _____ **Date of Birth** ____/____/____ **F** ☐ **M** ☐

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

Race: _____ **Decline:** _____ **Ethnicity:** _____ **Decline:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____ **Work:** _____ **Ext:** _____

Email Address: _____

In case of emergency, notify: _____ **Phone:** _____ **Relation to Patient:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Pharmacy's Name: _____ **Phone:** _____

Primary Care Physician's Name: _____ **Phone:** _____

Insurance Information

Primary Insurance Company: _____ **Phone:** _____

Insured's Name: _____ **DOB:** ___/___/___ **Relation to Patient:** _____

ID Number: _____ **Group Number:** _____

Secondary Insurance Company: _____ **Phone:** _____

Insured's Name: _____ **DOB:** ___/___/___ **Relation to Patient:** _____

ID Number: _____ **Group Number:** _____

I give my consent for The Heart of Texas Cardiology's physicians, employees or associates to leave messages on my answering or voice mail regarding my medical care, test results, appointment conformation and payment issues. I also give permission to discuss these listed issues with the following people:

_____ _____

Name/Relationship **Phone Number** **Name/Relationship** **Phone number**

I certify that the above insurance information is current and accurate; I authorize assignment of insurance benefits to Heart of Texas Cardiology, P.A. I understand that I am financially responsible for all charges whether is current or not paid by insurance. I authorize the use of my signature an all-insurance submission. The Heart of Texas Cardiology and its representatives may use my health care information and my disclose such information to the above- named insurance Company(s) and their agents for the purpose of obtaining payments for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the dated signed below.

I have been given the opportunity to review the HIPPA Disclosure Policy Regarding my Protected Health Information and understand the manner in which this office uses my information. I agree with the exception of: _____

_____ _____

Signature of Patient, Parent, or Guardian **Date**

_____ _____

Please print name of Patient, Parent, or Guardian **Date**