HEART CENTER OF NORTH TEXAS, PA

Patient Information Sheet

(Please Print)

PATIENT'S NAME _____ BIRTH DATE _____
LAST FIRST MIDDLE

HOME ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

NAME OF NURSING HOME, IF ANY _____

PRIMARY PHONE CIRCLE: CELL HOME WORK _____ OTHER PHONE CIRCLE: CELL HOME WORK _____

EMAIL ADDRESS _____ PREFERRED CONTACT METHOD _____

GENDER IDENTITY _____ BIRTH GENDER _____ SOCIAL SECURITY NUMBER _____

HISPANIC OR LATINO? YES NO RACE _____ PREFERRED LANGUAGE _____

MARITAL STATUS _____ SPOUSE'S NAME _____

EMERGENCY CONTACT NOT LIVING WITH YOU _____ RELATION _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

PRIMARY INSURANCE (If the patient is not the insured, please enter policy holder's information.)

INSURANCE COMPANY _____ PHONE _____

POLICY _____ GROUP _____

INSURED'S NAME _____ RELATION TO PATIENT _____

INSURED'S EMPLOYER _____ INSURED'S SSN _____ INSURED'S BIRTH DATE _____

SECONDARY INSURANCE

INSURANCE COMPANY _____ PHONE _____

POLICY _____ GROUP _____

INSURED'S NAME _____ RELATION TO PATIENT _____

INSURED'S EMPLOYER _____ INSURED'S SSN _____ INSURED'S BIRTH DATE _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS: I hereby assign, transfer and set over to the Heart Center of North Texas, PA all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

CONSENT TO TREAT: I hereby give consent to treat my medical condition and obtain medical information from other sources that may be pertinent to the continuation of my care.

Patient/Guardian Signature: _____DATE: _____