

Patient Information Sheet

Doctor: _____ Chart: _____ Facility: _____

Patient Information

Name: _____ Referring Doctor: _____ Phone: _____

Address: _____ Primary Doctor: _____ Phone: _____

Phone: _____ () Home () Work () Other

Phone: _____ () Home () Work () Other

Date of Birth: _____ Age: _____ Sex: _____

Social Security: _____ Relationship: _____

Marital Status: _____ () Married () Single

Employment:

Employed Retired Unemployed Disabled

Employer: _____ Name: _____

Address: _____ Phone: _____

Phone: _____ Relationship: _____

Responsible Party Information

Same as Patient Same as Responsible Party Other

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Social Security: _____

Date of Birth: _____

Primary Insurance

Same as Patient Same as Responsible Party Other

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Phone: _____

Policy Holder DOB: _____

Insurance Name: _____ Insured ID #: _____

Insurance Address: _____ Insured Plan/Group #: _____

Insurance Phone: _____

Secondary Insurance

Same as Patient Same as Responsible Party Other

Insured Party Name: _____ Relationship to Patient: _____

Insured Party Phone: _____

Policy Holder DOB: _____

Insurance Name: _____ Insured ID #: _____

Insurance Address: _____ Insured Plan/Group #: _____

Insurance Phone: _____

Responsible Party Signature

Please verify all information contained above, if any changes need to be made simply mark through the item and write in the correct information. By Signing below patient/guarantor agrees the above information is correct.

Authorization: I hereby authorize Cardiology Consultants of Texas to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges regardless of insurance coverage.

Responsible Party Signature _____ Date _____

General Consent for Treatment: I consent to and authorize Cardiology Consultants of Texas to treat any condition that I might have and seek treatment for.

Responsible Party Signature _____ Date _____ Parent Signature _____ Date _____
(If patient is a minor under 18 years of age)