

Patient Information Sheet

Doctor: _____ Chart: _____

Facility: _____

Patient Information

Name: _____

Referring Doctor: _____ Phone: _____

Address: _____

Primary Doctor: _____ Phone: _____

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

Emergency Contacts:

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

Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Phone: _____

Social Security: _____ Email Address: _____

Relationship: _____

Marital Status: _____ () Married () Single

Name: _____

Employment:

Phone: _____

Employed Retired Unemployed Disabled

Relationship: _____

Employer: _____

Spouse Information:

Address: _____

Name: _____

Phone: _____

Phone: _____

Responsible Party Information

Same as Patient

Employer Information:

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)