**Heart of Texas Cardiology, PA**
**Patient Information**
*Please fill out completely or mark areas "n/a" if they do not apply.*

Name (last, first, M.I._____

Sex ☐ M ☐ F Date of Birth _____/_____/_____ Age _____ Social Security # _____/_____/_____

Martial Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

Address_____City_____State_____Zip_____

Home Phone_____Work_____Cell/Pager _____

Employer_____ City_____State_____Zip_____ ☐ Retired

In case of emergency, notify_____Phone_____Relation to Patient_____

Address_____City_____State_____Zip_____

Primary Care Physician's Name_____ Phone: _____

## Insurance Information

Primary Insurance Company_____Phone_____

Insured's Name_____DOB_____/_____/_____Relation to Patient_____

ID Number _____Group Number_____

Employer Name_____

Secondary Insurance Company_____Phone_____

Insured's Name_____DOB_____/_____/_____Relation to Patient_____

ID Number _____Group Number_____

Employer Name_____

**I give my <u>consent</u> for The Heart of Texas Cardiology's physicians, employees or associates to leave messages on my answering machine or voicemail regarding my medical care, test results, appointment confirmation, and payment issue. I also give them permission to discuss these listed issues with the following people:**

_____ _____
Name/Relationship/Phone Number Date Name/Relationship/Phone Number Date

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 or not paid by insurance. I authorize the use of my signature on all insurance submissions. The Heart of Texas Cardiology and its representatives may use my health care information and may disclose such information to the above-named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I have been given the opportunity to review the HIPAA 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 Relationship to Patient