PATIENT INFORMATION

PATIENT NAME ____S.S. # ______________________________DOB _______________

HOME ADDRESS ____CITY, STATE, ZIP _____________________________________

HOME #_________________WORK #____________________ SEX ___M ___ F DRIVERS LIC # ___________________________

OCCUPATION _________________________________ EMPLOYER'S NAME ____

EMPLOYER'S ADDRESS ___________________________________CITY, STATE, ZIP ____________________________________

SPOUSE'S NAME ____S.S. # _______________________________DOB ______________

SPOUSE'S EMPLOYERS NAME ____WORK # ______________________________

SPOUSE'S EMP ADDRESS ___________________________________CITY, STATE, ZIP ___________________________________

***NOTIFY IN CASE OF EMERGENCY*: (Please provide name of friend or relative)**

NAME ______________________________________RELATIONSHIP _____________________PHONE #______________________

ADDRESS ____CITY, STATE, ZIP ___________________________________

NAME OF REFERRING DOCTOR ____PHONE # ________________

INSURANCE INFORMATION

INSURANCE CO NAME ____PHONE # _________________

NAME OF POLICYHOLDER _______________________________________RELATIONSHIP TO PATIENT _________________

ADDRESS OF INS CO _______________________________________CITY, STATE, ZIP ____________________________________

GROUP # _____________________________ ID/SUB # ____

MEDICARE # ___________________________________ MEDICAID # ______________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Diagnostic Cardiology of Houston, P. A. to furnish information to my insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by my insurance carrier.

SIGNATURE ____DATE _______________