

AngioCardiac Care of Texas P.A

AMIN H. KARIM M.D.

Cardiology

SHAHNAZ A. KARIM MD

Physical Medicine and Rehab.

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| TODAY'S DATE: | | For Office Use Only: PATIENT NO. | |
| LAST NAME: | | FIRST NAME: | MIDDLE NAME: |
| BIRTH DATE: | | AGE: | SEX: |
| MARITAL STATUS: | | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | |
| SOCIAL SECURITY NUMBER: | | DRIVER'S LICENSE NO. | State: |
| HOME ADDRESS: | | | |
| CITY: | STATE: | ZIP: | COUNTRY: |
| Phone: | Mobile:: | E mail: | |
| EMPLOYER: | | | |
| OFFICE ADDRESS: | | | |
| CITY | STATE: | ZIP | COUNTRY: |
| Phone | Pager:: | E mail | |
| SPOUSE NAME: | | | |
| EMERGENCY CONTACT: | | Relationship: | |
| Work Phone: | Home Ph: | Mobile: | |
| REFERRAL PHYSICIAN NAME : | | Phone: | |
| INSURANCE INFORMATION | | | |
| NAME OF INSURED: | | SS # | |
| PRIMARY INSURANCE COMPANY: | | | |
| Address: | | | |
| Policy Number: | | Group Number: | |
| SECONDARY INSURANCE COMPANY: | | | |
| Name of Insured (if different from above) | | | |
| Address: | | | |
| Policy Number: | | Group Number: | |
| OTHER HEALTH INSURANCES: | | | |
| AUTHORIZATION | | | |
| <p><i>I hereby authorize ANGIOCARDIAC CARE OF TEXAS, AMIN H.KARIM MD, SHAHNAZ A. KARIM or associates top examine and treat me. I also authorize to release to my Insurance Company any information acquired in the course of my examination or treatment. I herreby authorize payment directly to ANGIOCARDIAC CARE OF TEXAS, AMIN H. KARIM MD OR SHAHNAZ A. KARIM MD for surgical and/or medical benefits otherwise payable to me for services rendered. If benefits are payable to me I authorize my Insurance Company or Medicare or Medicaid to furnish to my doctor any information in the adjudication of any claims in regards to services furnished to me.</i></p> <p><i>I hereby authorize the use of a photographic reproduction of this authorization in place of the original. I also understand that in case of electronic transmittal of claims to Insurance Company the notation "Signature on record" will be used.</i></p> <p><i>This authorization is valid till I or my legally designated representative revokes it in writing.</i></p> | | | |
| YOUR SIGNATURE _____ | | TODAY'S DATE _____ | |