AngioCardiac Care of Texas P.A. **Main Heart Clinic** **OneStop Medical Care**

PATIENT REGISTRATION

TODAY'S DATE:			**For Office Use Only: PATIENT NO.**	
LAST NAME:		FIRST NAME:		MI:
BIRTH DATE:		AGE:		SEX:
MARITAL STATUS:	❒ Single	❒ Married	❒ Divorced	❒ Widowed
SOCIAL SECURITY NUMBER:		DRIVER'S LICENSE NO.		State:
HOME ADDRESS:				
CITY:	STATE:	ZIP:	COUNTRY:	Phone: Leave voice message: □ Y □ N
Mobile::		Leave voice message/send text : □ Y □ N		E mail:
EMPLOYER:				
EMPLOYER ADDRESS:				
	CITY	STATE:	ZIP	COUNTRY:
	Phone	Pager::	E mail	
SPOUSE NAME:				
EMERGENCY CONTACT:			Relationship:	
	Work Phone:	Home Ph:	Mobile:	
REFERRAL PHYSICIAN NAME :			Phone:	
Date of illness/Injury/Accident:			If Auto Accident, State where occurred:	
Insured Party/Responsible Party Information (Leave Blank of same as patient)				
Last Name:		First Name:		MI
Social Security Number:		Date of Birth:		Relationship to Pt:
Address:				CIty:
St:	Zip:	Work Ph:		Home Ph:
INSURANCE INFORMATION				
NAME OF INSURED:			SS #	
PRIMARY INSURANCE COMPANY:			Policy #	Group#
	Address:			
SECONDARY INSURANCE COMPANY:			Policy #	Group#
	Name of Insured (if different from above)			
	Address:			
OTHER HEALTH/AUTO INSURANCE:				
"I have received and read a copy of this office's NOTICE OF PRIVACY PRACTICES" Sign:				

AUTHORIZATION

I hereby authorize ANGIOCARDIAC CARE OF TEXAS, AMIN H.KARIM MD, SHAHNAZ A. KARIM , SUSAN J. GARRISON or associates to 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 hereby authorize payment directly to ANGIOCARDIAC CARE OF TEXAS 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 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 agree to receive text reminders on my cell phone.

This authorization is valid till I or my legally designated representative revokes it in writing.

_____ YOUR SIGNATURE

_____ TODAY'S DATE