

# *Houston Cardiac Association*

## *New Patient Information*

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph#: \_\_\_\_\_ Wk Ph# \_\_\_\_\_ Cellular \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ TDL \_\_\_\_\_  
Marital Status: Single \_\_\_ /Married \_\_\_ /Widowed \_\_\_ /Divorced \_\_\_ /Separated \_\_\_ /

Patient Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Business Phone #: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Wk Ph# \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_

In Case of an Emergency: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Wk Ph# \_\_\_\_\_  
Relationship: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_  
Referred by: \_\_\_\_\_

### Insurance Information

Do you have Medicare: Yes \_\_\_ No \_\_\_ Medicare Number \_\_\_\_\_  
Do you have Medicaid: Yes \_\_\_ No \_\_\_ Medicaid Number \_\_\_\_\_  
Name of Commercial Insurance: \_\_\_\_\_  
Group/Policy Number: \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

I hereby assign, transfer, and set over to Houston Cardiac Association all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_