Cardiology Services of East Texas

PATIENT INFORMATION **DATE**_____

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME#:_____DAY/CELL#:_____SS#:_____

DATE OF BIRTH:_____ SEX: M ___/ F___ RACE:_____DL#:_____

MARITAL STATUS:_____ E-mail_____OCCUPATION:_____

EMPLOYER'S NAME & ADDRESS:_____

SPOUSE'S NAME:_____DOB:_____SS#: _____

SPOUSE'S OCCUPATION:_____WORK#: _____

SPOUSE'S EMPLOYER'S NAME & ADDRESS: _____

PRIMARY CARE PHYSICIAN:_____PHONE#: _____

REFERRING PHYSICIAN:_____PHONE#: _____

VA PHYSICIAN IF APPLICABLE:_____ CLINIC ADDRESS:_____

CHIEF COMPLAINT: _____

IN CASE OF EMERGENCY, CONTACT

NAME: _____ RELATIONSHIP TO PT: _____ PHONE#: _____

INSURANCE INFORMATION:

Primary Insurance:_____

Name of Insured:_____ Relationship to PT_____DOB:_____

Secondary Insurance:_____

Name of Insured:_____ Relationship to PT_____DOB:_____

PHARMACY INFORMATION:

Pharmacy_____ Address_____

Phone#_____ Fax#_____

Mail Order pharmacy_____ Phone# _____ Fax#_____

Member ID#_____ Member Name:_____

Name of Plan_____ Medicare Part D: ___yes ___no

Please give your insurance card and driver's license to receptionist to copy.

I hereby authorize payment of medical benefits to the above named physician for all services rendered. I understand that I am financially responsible for any balance not covered by my insurance carrier. I authorize the above named physician's office to mail, copy, or request medical records from health care providers, agencies, and insurance carriers, as needed.

_____

{PATIENT OR RESPONSIBLE PARTY'S SIGNATURE}

CAET
CARDIOVASCULAR ASSOCIATES OF EAST TEXAS
Affiliated with
Louis & Peaches Owen HEART HOSPITAL
TRINITY MOTHER FRANCES