TEXAS CARDIOLOGY ASSOCIATES

PATIENT REGISTRATION & AUTHORIZATION

NAME: _____ DATE OF BIRTH: _____

Gender: ☐ Male ☐ Female Social Security Number: _____

Marital Status (Circle One): Married Single Other

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Contact Phone: _____

Email Address: _____

Contact Preference (Circle One): Mail Home Phone Cell Phone Work Phone Email

CONSENT FOR TREATMENT AND SERVICES

The reason for requesting services at Texas Cardiology Associates is that a medical condition requiring care exists. I, for myself or for this patient, consent to the medical care and treatment which my physician(s) considers to be necessary. I understand that I may have these services provided at another location, but agree to have it performed here.

RELEASE OF INFORMATION

I hereby authorize the release of any medical and/or other information necessary to process my claim(s) and to referring physician(s). In addition, I authorize the release of any medical information from other physician, hospital, or medical services to Texas Cardiology Associates as deemed necessary for my care. This is a lifetime authorization unless specifically revoked in writing by the undersigned.

INSURANCE AUTHORIZATION

I hereby assign Texas Cardiology Associates all benefits which are or shall become payable from any third party payor who is responsible for payment of my Texas Cardiology Associates medical expenses. I authorize and direct all third party payors to pay all benefits directly to Texas Cardiology Associates. This is a lifetime authorization unless specifically revoked in writing by the undersigned.

FINANCIAL RESPONSIBILITY

Although Texas Cardiology Associates try to provide an estimate of cost as a courtesy, I understand that I am financially responsible for patient financial responsibility as indicated by my insurance company when claims are processed, or if a cash pay patient, the estimate given for services. My insurance company sets the actual cost for what I am responsible for. I will confirm with my insurance company if I have any doubts about cost for services.

_____ _____

SIGNATURE DATE

275 West Campbell Road, Suite 120 · Richardson, Texas 75080
214-393-6877 Phone · 214-393-6879 Fax

TEXAS CARDIOLOGY ASSOCIATES

PATIENT REGISTRATION FORM

NAME: _____ DATE: _____

Referring Physician: _____

Referring Physician Phone Number: _____

Previous Cardiologist: _____

Previous Cardiologist Phone Number: _____

MISCELLANEOUS INFORMATION

Census Bureau Race (Circle One):

American Indian or Alaskan Native Asian Black or African American White

Black Hispanic or Latino Native Hawaiian or Pacific Islander White Hispanic or Latina

Language Preference: _____

EMERGENCY CONTACT INFORMATION

Emergency contact person name? _____

Emergency contact phone? _____

Emergency contact's relationship to patient? _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes ☐ No

If yes, name of insurance? _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Patient's relationship to subscriber (Circle One): Self Spouse Child Other

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