Patient Information

Phone: (512) 807-3150
Toll-free: (888) 816-1614
Fax: 512-807-3399
www.tcaheart.com

TEXAS CARDIAC ARRHYTHMIA

Date:
Email:
Patient Name:
Physical Address:
City:
State: **Zip Code:**
Alt/PO Box:
City:
State: **Zip Code:**
SSN:
Date of Birth:
Sex: ☐ Male ☐ Female
Home Phone:
Mobile Phone: **Work:**

Marital Status

☐ Single ☐ Divorced
☐ Married ☐ Widowed

How did you learn about our practice?

☐ Referring Physician ☐ Magazine/Newspaper
☐ Television ☐ Radio ☐ Other

Employment Status

☐ Employed **Employer:**
☐ Unemployed **Occupation:**
☐ Retired

Would you like a copy of reports sent to your Primary Care Physician? ☐ Yes ☐ No

Primary Care Physician

Physician Name:
Address:
Phone:

Referring Physician

Physician Name:
Address:
Phone:

Insured Information

Name: **Relationship to patient:**
Date of Birth: **SSN:**

Insurance Information

Primary Insurance: **Secondary Insurance:**
Policy/Member ID: **Policy/Member ID:**
Group Number: **Group Number:**

Emergency Contact

Name: **Home Phone:**
Relationship: **Work Phone:**

The undersigned hereby assigns to St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia, all rights, title and interest in any payment due and/or undersigned for medical care, services, or supplies described in any health-insurance claim form or statement issued by St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia. The undersigned understands that this agreement will not eliminate or effect in anyway the obligation of the patient and/or undersigned to St. David's Heart & Vascular d.b.a. Texas Cardiac Arrhythmia for all services and supplies rendered, including, nut not limited to, any co-payments or deductibles required by a particular health-care program or plan.

Patient Signature and Date

Release of Medical Information

I hereby authorize the releaser of any medical records, inclusive of all results of any testing and other pertinent information acquired during my treatment, to the physician as deemed necessary. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Insured Signature and Date **Witness Signature and Date**