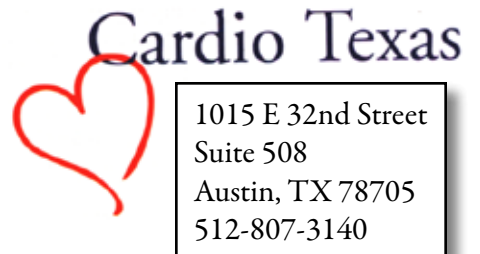


# Patient Registration Form



Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_

Cell # \_\_\_\_\_ Work # \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

EMAIL: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Policy/Member Id: \_\_\_\_\_

Group# \_\_\_\_\_

Policy Holder: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy/Member Id: \_\_\_\_\_

Group# \_\_\_\_\_

Policy Holder: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**Gender:** Male Female

**Marital Status:**

Single Married Divorced

Widowed Other

**Employment Status:**

Employed Unemployed Retired

Employer Name: \_\_\_\_\_

**In Case of Emergency, Please Contact:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home# \_\_\_\_\_

Other# \_\_\_\_\_

Pharmacy \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

## How did you learn about us:

Doctor TV Radio Newspaper Yellow Pages Internet Friend/Relative/Other: \_\_\_\_\_

Patients who do not have insurance are expected to pay charges in full at the time services are rendered. I hereby assigns to Cardio Texas, PLLC all right, title and interest to which I am entitled in any payment due and/or undersigned for medical care, services, or supplies described in any health-insurance claim form or statement issued by Cardio Texas, PLLC. I understand that this agreement will not eliminate or effect in any way my obligation and/or undersigned to pay Cardio Texas, PLLC for all services and supplies rendered, including, but not limited to, any co-payments or deductibles required by a particular health-care program or plan.

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

I authorize a Cardio Texas, PLLC physician, and/or a mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Cardio Texas, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

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

I hereby authorize the release 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.

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

CTX Initials: \_\_\_\_\_