

**THE HEART INSTITUTE OF EAST TEXAS**

Please circle the Doctor you are here to see:

Bachireddy	Chandra	M Khan
Kovvali	Hudson	Kedia
Mani	I Khan	Manda
	Velagapudi	

Date \_\_\_\_\_

How did you hear about The Heart Institute?

- Physician Referral    Advertisement  
 Friend    Other Please Specify \_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_ Social Security # last 4 digits only xxx-xx-\_\_\_\_\_

Last                                  first                                  middle

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph. \_\_\_\_\_ Business Ph. (\_\_\_\_\_) \_\_\_\_\_ Cell Ph. (\_\_\_\_\_) \_\_\_\_\_

Married    Single    Widow    Divorced   Age \_\_\_\_\_ Date of Birth \_\_\_\_\_    Male    Female

Employer Name \_\_\_\_\_  
 Full-Time    Part-Time    Retired    Self-Employed    Student - Fulltime    Student - Part-time

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Pharmacy \_\_\_\_\_ Allergies \_\_\_\_\_

**Insured Name ( If no insurance, responsible party )**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Cell# \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Address \_\_\_\_\_

**Notify In Case of Emergency**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

**Insurance Information - Copies of Insurance Cards and Drivers License are Required**

Insurance 1 \_\_\_\_\_

SS# \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Insurance 2 \_\_\_\_\_

SS# \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

**Authorizations**

For and in consideration of the services rendered by THE HEART INSTITUTE OF EAST TEXAS, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible, copayment and coinsurance charges not covered by my insurance policy and charges not covered as a result of any law settlements or judgments obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my insurance policy, to include, charges for services deemed experimental, investigational and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and assign THE HEART INSTITUTE OF EAST TEXAS all rights, title and interest in any payment due me for services described herein as provided in the above mentioned policies of insurance/settlements or judgments. I hereby consent to the release of information necessary to process claims with my insurance policy. I understand that the specific information to be released may include, but is not limited to history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the receipt of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Patient Name (Please Print) \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_