THE HEART INSTITUTE OF EAST TEXAS

Date _____

How did you hear about The Heart Institute?

☐ Physician Referral ☐ Advertisement

☐ Friend ☐ Other Please Specify _____

Please circle the Doctor you are here to see:

Ravinder Bachireddy, MD	Ilyas M Khan, MD
J S Chandra, MD	Yugandhar Manda, MD
Venkata R Kovvali, MD	George Vettiankal, MD
Kevin L Hudson, DO	Aditya Saini, MD
M. Musa Khan, MD	Mikkhail Narezkin, MD
Cheriparambil K Mani, MD	Subramanya Venkata, MD

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** _____