Patient Registration Form

Patient Information					
Last Name		First Name		Middle Initial	
Date of Birth	Social Security Number		Gender		
Street Address		Apt.	City	State	Zip
E-Mail Address			Work Number		
Home Phone		Cell Phone or Other			
Emergency Contact Name		Emergency Contact Number		Relationship	
Referring Provider (This section MUST be completed for Insurance Purposes)					
Physician's Name			Phone Number		
Insurance Information					
Primary Insurance	Insurance Phone		Subscriber Name	Relationship	
ID Number	Group Number		Subscriber SS#	Date of Birth	
Address of Insurance (Street or P.O. Box, City, State Zip)					
Secondary Insurance	Insurance Phone		Subscriber Name	Relationship	
ID Number	Group Number		Subscriber SS#	Date of Birth	
Pharmacy Name & Telephone Number:					

I hereby authorize Dallas Heart & Vascular Consultants to perform medical services and bill my insurance company for services and the release of these reports requested by my physician or insurance company and/or to their designate(s) when necessary to process the claim for clinical review. Dallas Heart & Vascular Consultants will send the claim to the listed insurance carriers as a courtesy. The policy holder or subscriber is responsible for understanding the parameters of their insurance (i.e.: In-network, out-of-network, deductibles, co-pays and if a pre-authorization is needed for ordered tests. If, for any reason, your insurance company does not cover any performed services, the subscriber is responsible for payment of outstanding balances. ***Thank You!***

Signature (Responsible Party): ____

Date: ______________________________