The Woodlands
Heart & Vascular Center

PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last)*_____

Date of Birth _____ Age _____ Male / Female Marital Status: S M W D

Address _____

Phone Number _____ S.S.N. # _____ D.L. #_____

Employer _____ Phone _____

Employer Address _____

Referring Physician _____ Phone _____ Fax _____

Pharmacy _____ Phone _____

Emergency Contact _____ Phone _____

Insurance Information

Primary Insurance _____ Phone _____

Policy # _____ Group # _____ Effective Date _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Secondary Insurance _____ Phone _____

Policy # _____ Group # _____ Effective Date _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

I hereby authorize *The Woodlands Heart and Vascular Center* to apply for benefits on my behalf for covered services rendered by the physician. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I authorize the release of any medical information needed to process this claim and all future claims. I permit a copy of this authorization to be used in place of the original. I authorize that payment from my insurance company be made directly to *The Woodlands Heart and Vascular Center*. I also authorize consent for treatment of any and all medical services performed. This authorization will remain valid until I revoke it by written notice.

Patient Signature _____ Date _____