



Patient Information

CARDIAC ASSOCIATES OF DALLAS | 7777 Forest Lane, B-432 | Dallas, TX 75230 | 972-566-8474

Patient

Last: _____ First: _____ MI: _____ Sex _____ DOB: _____ Age: _____

SS#: _____ Home #: _____ Work #: _____ Mobile #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Employer's #: _____

Responsible Party's Name (Person Responsible For Bill)

Last: _____ First: _____ MI: _____ DOB: _____

Street Address: _____ City: _____ State: _____ Zip: _____
(if different from above)

Phone #: _____ Social Security number: _____

Emergency Contact

Last: _____ First: _____ Relationship: _____

Home phone: _____ Work Phone: _____ Mobile: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Nearest Relative Not Living With You

Last: _____ First: _____ Relationship: _____

Home phone: _____ Work Phone: _____ Mobile: _____

Street Address: _____ City: _____ State: _____ Zip: _____

How Did You Hear About Us?

_____ My doctor Referred me _____ Friend/Family _____ Internet/Web Site

_____ Magazine Article/ Print Advertisement _____ News Story/Radio/Television

Primary Insurance Carrier Information

Name of carrier: _____ Claims Mailing Address: _____
Insured's Name: _____ DOB: _____ SS# _____ Relationship: _____
Insurance phone #: _____ Policy #: _____ Group #: _____

Secondary Insurance Carrier Information

Name of carrier: _____ Claims Mailing Address: _____
Insured's Name: _____ DOB: _____ SS# _____ Relationship: _____
Insurance phone #: _____ Policy #: _____ Group #: _____

Referring Physician: _____ **Phone #:** _____

Primary/Family Physician (PCP): _____ **Phone #:** _____

Credit Policy

All services rendered by Cardiac Associates of Dallas are charged directly to the patient. We will be happy to file all necessary insurance forms at no charge and credit their payments to your account.

Unless we are contracted with your insurance carrier as a participating provider to accept what they approve, your deductible or the percentage not covered by the carrier is due at the time of service. Managed care co-pays are due the time of service.

If you do not have insurance, payment arrangements **must be made prior to service**. If you first saw the physician in the hospital, payment arrangements must be made immediately after hospital discharge.

Payment of your charges is ultimately your responsibility and you as the patient agree to comply with our policy.

Signature: _____ **Date:** _____

Consent of Professional Services/Information & Release/Assignment of Benefits

I consent to treatment/services necessary for the care of my present medical condition.
I authorize holder of medical and other information about me to release any information needed to determine benefits.
I hereby assign, transfer and set over to Cardiac Associates of Dallas my assignment of benefits for reimbursement of services.
This consent/authorization/assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for any charges not paid by said insurance carrier(s).

Signature: _____ **Date:** _____

Insured's Signature: _____ **Date:** _____

**Disclosure of Medical/Financial Information
To Friends and Family**

Name of Patient: _____ Date of Birth: _____ Social Security#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

I, the undersigned, hereby authorize Cardiac Associates of Dallas to disclose information from my medical or financial record to the following people:

Name: _____ Relationship: _____

Contact Information: _____

Type of information that may be released: _____ Medical _____ Financial _____ Both

Name: _____ Relationship: _____

Contact Information: _____

Type of information that may be released: _____ Medical _____ Financial _____ Both

This Authorization is given freely with the understanding that:

1. I may revoke this authorization at any time, but not retroactively, by letting facility know in writing.
2. The facility, its employees, officers, and the physicians are hereby released from legal responsibility or liability for disclosure of the information I authorized previously.

Patient Name (printed): _____

Date: _____

Patient Signature: _____

(or personal representative's signature)

SSN#: _____

(for ID purposes only)

Witness Name (printed): _____

Date: _____

Witness Signature: _____

Personal Representative's Authority: _____