The Heart Center

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290 East Medical Center Blvd, Webster, TX 77598

Patient Information (Please Print)

Patient Name: ____
Last First M

Address: ____
Street City State Zip

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Email address: __________________________ **How did you hear about us?** ________________________

Primary Care Physician: ________________________

Social Security: ______________________ Gender: M F DOB: ______________ Age: _______

Employer: ____________________ Occupation: _________________ Marital Status: S M D W

Employer's Address: ____
Street City State Zip

Spouse: ________________________ Spouse's Employer: _________________ Phone: ___________

Insurance Information:

Insurance Company: ____________________ Insured Name: __________________________________

Insured relationship to patient: ________________ Insured Employer: __________________________

Insured Social Security #: ____________________ Insured Date of Birth: _____________________

Patient Contact Information/Emergency Contact:

Name: ____
Last First M.

Address: ____
Street City State Zip

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Relationship to patient: ____

Release of Authorization/Assignment of Benefits:
I authorize the release of information of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physician. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

Signature: ______________________________________ Date: ____________________________

Patient Questionnaire

Name: ___________________ Date: ____________ Referring physician: _______________

Your Medical History: (Check each one that applies)

( ) Heart Disease
( ) Gastro esophageal Reflux
( ) Diabetes
( ) Stroke
( ) Asthma/Pneumonia
( ) Psychological problems / Clinical Depression
( ) Cancer
( ) Abnormal Heart Valve requiring antibiotics when visiting the dentist
( ) Kidney / Bladder Disease
( ) Liver Disease
( ) Thyroid Problem
( ) AIDS or HIV +
( ) Hepatitis A / Hepatitis B / Hepatitis C
( ) Glaucoma

LIST MAJOR ILLNESSES & SURGERIES YOU HAVE HAD:

____

MEDICATIONS/DOSES YOU ARE CURRENTLY TAKING:

____

____

PHARMACY NAME & ADDRESS: ____

ALLERGIES:

____

____

DO YOU HAVE A HISTORY OF SMOKING: _____ Yes ___No ALCOHOL: _____Yes ____No

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I have read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time.

I understand that I may request a copy of your Notice of Privacy Practices as well may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____________________________ Date: _________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ____________________ Initials: _________ Reason: ___________________________