Cardiology Consultants of Houston, PLLC **Patient Demographics/Insurance Update Form**

Patient Name:				**DOB:**	**Age:**
Address:				**SSN:**	
				Sex:	
Home:	☐ Preferred	**Work:**	☐ Preferred	**Marital Status:**	
Cell:	☐ Preferred	**Email:**			☐ Preferred

Due to new federal regulations, we are required to collect the following information from every patient.

Race:	**Please place your initials in this box if you choose not to provide this new information.**
Preferred Language:	

Primary Care Physician:	**Phone:**	**Fax:**
Referring Physician:	**Phone:**	**Fax:**

Insurance Information

Primary Insurance	**Secondary Insurance**
Company:	**Company:**
Subscriber Name:	**Subscriber Name:**
DOB:	**DOB:**
Relationship:	**Relationship:**
Subscriber ID:	**Subscriber ID:**
Group Number:	**Group Number:**

Employer Information

Employer:
Address:
Phone Number:

Guarantor Information

Name:
Address:
Phone Number:

Emergency Contact (Please include someone who DOES NOT live with you)

Name:	**Relationship:**	**Phone:**

I HEREBY ASSIGN, TRANSFER, AND SET OVER TO **CARDIOLOGY CONSULTANTS OF HOUSTON**, ALL OF MY RIGHTS, TITLE, AND INTEREST TO MY MEDICAL REIMBURSEMENT BENEFITS UNDER MY INSURANCE POLICY. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NEEDED TO DETERMINE THESE BENEFITS. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL WRITTEN NOTICE IS GIVEN BY ME, REVOKING SAID AUTHORIZATION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE.

Signature:	**Date:**