FORT BEND HEART CENTER
Patient Registration Form

Name: _____ *SSN:* _____

Date of Birth: _____ *Marital Status: S M W D Sep*

Street Address: _____

City: _____ *State:* _____ *ZIP:* _____

Home: _____ *Cell:* _____ *Work:* _____

Referred by: _____

Spouse's Name: _____ *Spouse's contact:* _____

Emergency Contact: _____ *Telephone #:* _____

PATIENT EMPLOYER INFORMATION:

Employer Name: _____ *Ph:* _____

Employer Address: _____

City: _____ *State:* _____ *ZIP:* _____

Patient's Occupation: _____

PRIMARY INSURANCE INFORMATION

Insurance Company : _____ *Ph:* _____

Policy #: _____ *Group #:* _____

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original.

Signature: _____ *Date:* _____

I hereby authorize Dr. _____ *to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to Dr.* _____ *(or to the party who accepts assignment).*
I certify that the information I have reported with regard to my insurance coverage is correct.
I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

Signature: _____ *Date:* _____