Advanced Heart Care, PA

Account #_____

Physician_____

Patients Name:_____
(Last) (First) (MI)

Street Address:_____ City:_____State:_____ Zip:_____

Social Security Number:_____ Phone Number:_(_____)_____

Cell Number: ( ) _____ Email : _____

Sex:__M__F__ Date of Birth:_____/_____/_____ Age:_____ Marital Status:__M__S__W__D__

Spouse's Name:_____ Social Security # :_____ Date of Birth:____/____/____

Responsible Party's Name:_____
(Last) (First) (MI)

Street Address:_____ City:_____State:_____ Zip:_____

Social Security Number:_____ Phone Number:_(_____)_____

Nearest Relative Not Living With You:_____
(Name) (Phone Number)

Referring Physician:_____ Address or Phone #:_____

Family Doctor:_____ Address or Phone #:_____

Employer:_____

Phone Number:_____

Spouse's Employer:_____

Phone Number:_____

**Ownership Disclosure*

In the event you and your physician choose the Heart Hospital Baylor Plano for your cardiovascular care, the Heart Hospital Baylor Plano is the first and only freestanding, full-service hospital dedicated solely to heart and vascular care in N. Texas. It was created through a partnership between Baylor Regional Medical Center at Plano and 86 cardio-vascular specialists, including your physician. This notice is to inform you that, through this partnership, your physician has a financial ownership interest in the Heart Hospital Baylor Plano.

If you are considering services at Hopkins County Memorial Hospital we hereby notify you that your physician may have an ownership interest in the cardiovascular services provided therein.

PLEASE PRESENT INSURANCE CARDS & PHOTO ID TO THE RECEPTIONIST FOR COPIES TO BE MADE

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification or second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

(Signature)