

ADVANCED CARDIOLOGY OF TEXARKANA

Patient Registration

Please answer ALL questions

Date _____

Which provider are you seeing: Please circle one

- **Dr. Black**
- **Dr. Cantor**
- **Dr. Formes**
- **Nurse Practitioner**

Date of Birth: _____

Name: _____

Address: _____

City, _____ State, _____ Zip, _____

Mailing address if different: _____

Patients Social Security Number: _____

Married ___ Divorced ___ Single ___ Widowed ___

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ E-mail: _____

Employer's Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Nearest relative NOT LIVING WITH YOU: _____

Home Telephone: _____ Work Telephone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Is this an HMO? Yes _____ No _____

Policy Holder: _____ ID # _____

Policy Holder Date of Birth _____ Social security # _____

Secondary Insurance Company: _____

Policy Holder: _____ ID # _____

Policy Holder Date of Birth _____ Social security # _____

Who is your Primary Care Physician? _____

HIPPA AUTHORIZATION

I _____ hereby authorize Advanced Cardiology of Texarkana to discuss my medical and health information, in order to best coordinate my care, with the following people:

Name _____ Relationship _____

Telephone Number: _____

Address: _____

Name _____ Relationship _____

Telephone Number: _____

Address: _____

Name _____ Relationship _____

Telephone Number: _____

Address: _____

Signature

Date

Office Use Only

Data Complete _____

Insurance verified _____

Signature obtained _____