Heart Clinic of San Antonio
502 Madison Oak Suite 250
San Antonio, TX 78258
Phone: (210) 483-8883 Fax: (210) 494-1740

OFFICE USE ONLY
Scanned _____

Patient Demographics

Name
Last _____ **First** _____
DOB _____
Address _____
City/State _____
Zip Code _____
Soc. Sec. Num. _____
Sex □**M** □**F**

Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

Marital Status
□Single □Divorced
□Married □Widowed

Preferred Pharmacy
Address _____
Phone _____
Fax _____

Employment Status
□Employed Employer _____
□Unemployed Occupation _____
□Retired

Referring Physician
Physician Name _____
Address _____
Phone _____
Fax _____

Other Physicians
Physician Name/Specialty _____
Physician Name /Specialty _____
Physician Name/Specialty _____
Physician Name/Specialty _____

Insured Information
Name of cardholder _____
Date of Birth _____

Relationship to Patient _____
Soc. Sec. Num. _____

Insurance Information
Primary Insurance _____
Policy/Member ID _____
Group Number _____

Secondary Insurance _____
Policy/Member ID _____
Group Number _____

In Case of Emergency
Name _____
Relationship _____

Home Phone _____
Alt Phone _____

Payment Policy

I, the undersigned authorize payment of medical benefits to the Heart Clinic if San Antonio, P.A., for any services furnished by the physician or his staff. I understand that I am financially responsible for any amount not covered by my contract. I also authorize the Heart Clinic if San Antonio, P.A., to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits.

Patient signature _____

Cancellation Policy

1. Failure to cancel with at least 24 hour notice will result in a **$25 cancellation charge**.
2. Failure to show for appointment without any notification will result in a **$50 no show charge.**
3. Failure to cancel **Nuclear Stress Test** appointments with at least 24 hour notice will result in a charge for the Lexiscan medication (price to be disclosed as needed).

I have read and fully understand the above policy

Patient Signature _____