For Office Use Only
Verified Date: _____
By: _____
System Account#: _____

TEXAS VEIN HEALTH
VIJAY S. RAMANATH, MD

HeartPlace®

How did you hear about us?

❑ Physician Referral ❑ Advertisement
❑ Friend ❑ Other: _____ Date: _____

Patient Information

Name: _____ Doctor: _____
last first middle

Social Security #: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph.: (_____) _____ Business Ph.: (_____) _____ Cell Ph.: (_____) _____

❑ Married ❑ Single ❑ Widow ❑ Divorced Age: _____ Date of Birth: _____ ❑ Male ❑ Female

Employer Name: _____ Employer Address: _____

❑ Full-Time ❑ Part-Time ❑ Retired ❑ Self-Employed ❑ Student Full-Time ❑ Student Part-Time

Referring Physician: _____ Referring Physician Ph.: (____) _____

Primary Care Physician: _____ Primary Care Physician Ph.: (____) _____

Insured Name (If no insurance, responsible party)

Name: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph.: (_____) _____ Business Ph.: (_____) _____ Cell Ph.: (_____) _____

Employer Name: _____ Employer Address: _____

Notify In Case of Emergency

1. Name: _____ Relationship: _____ Ph.#: _____ Wk.#: _____

2. Name: _____ Relationship: _____ Ph.#: _____ Wk.#: _____

Insurance Information – Copies of Insurance Cards and Drivers License are Required

Insurance 1: _____

Address: _____ Ph.#: (____) _____

SS#: _____ Policy #: _____ Group #: _____

Insurance 2: _____

Address: _____ Ph.#: (____) _____

SS#: _____ Policy #: _____ Group #: _____

Authorizations

For and in consideration of the services rendered by TVH/HeartPlace, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible, copayment and coinsurance charges not covered by my insurance policy and charges not covered as a result of any law settlements or judgements obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my insurance policy, to include, charges for services deemed experimental, investigational and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and as sign TVH/HeartPlace all rights, title and interest in any payment due me for services described herein as provided in the above-mentioned policies of insurance/settlements or judgements. I hereby consent to the release of information necessary to process claims with my insurance policy. I understand that the specific information to be released may include, but is not limited to history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the receipt of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Patient Signature: _____ Date: _____

Patient Name (Please Print): _____

Witness Signature: _____ Date: _____