

Texas Vascular Associates, PA
Demographic Information

Patient Name: _____ Male/Female _____

(please circle)

Birth Date: _____ Social Security Number: _____

Patient Street Address: _____

_____ City State Zip Code

Home Phone: (____) _____ Cell Phone : (____) _____ Work Phone: (____) _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Home # (____) _____ Cell # (____) _____

If the patient is in a nursing home, please provide the name, address and telephone number:

Name of Facility Address Telephone number

Insurance Information

(This must be completed even if we have copies of your card)

Primary Insurance Company: _____

Policy ID # _____ Group # _____

Name of Policy Holder: _____ Relationship to Patient _____

Policy Holder Birth date: _____ Policy Holder SS# _____

Secondary Insurance Company: _____

Policy ID # _____ Group # _____

Name of Policy Holder: _____ Relationship to Patient _____

Policy Holder Birth date: _____ Policy Holder SS# _____

Acknowledgement of Review of Privacy Practices

I have been offered and/or reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

If patient is unable to sign, please list name of Personal Representative: _____

Description of Personal Representative's Authority: _____