Heart and Vascular Clinic of San Antonio

☐ **New Patient** ☐ **Established Patient**

Last Name: _____ First Name: _____ MI: _____

Address: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____/_____/_____ Social Security # _____ _____ _____

Email Address: _____ Employment Status: _____

Marital Status: ☐Married ☐Divorced ☐Widowed ☐Legally Separated ☐ Partner ☐Other

Spouse Name: _____ Date of Birth: _____/_____/_____

Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or other Pacific Islander
☐Black or African American ☐White ☐ Hispanic ☐ Other race _____
☐Rather not say

PCP, Primary Doctor's Name: _____ Phone # _____

Preferred Pharmacy: _____ Phone # _____

Pharmacy Address: _____ Fax # _____

Emergency Contact: _____Relationship: _____ Phone # _____

We are committed to providing private and efficient communication with you. Please indicate the preferred method(s) of contact should we need to reach you by phone:

☐ HOME: ___ Message to Return call ___ Detailed Message (results, treatment, etc.)

☐ WORK :___ Message to Return call ___ Detailed Message (results, treatment, etc.)

☐ CELL: ___ Message to Return call ___ Detailed Message (results, treatment, etc.)

I hereby authorize Heart and Vascular Clinic of San Antonio, PLLC to use and/or disclose my health information, which specifically identifies me or what can be reasonably be used to identify me to carry out my treatment, payment and other health care operations. My protected health information may be released to the following Individual(s):

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Patient Signature: _____ Date: _____

927 McCullough Ave, San Antonio, TX 78215 Tel: 210-223-6896 Fax: 210-223-3888