Cardiovascular Wellness Center of Texas
www.cvwellnesscenter.com

300 N. Highland, Suite 365
Sherman, TX 75092
(903) 892-2030

Fax: 855-373-0004

4510 Medical Center Drive, Suite 204
McKinney, TX 75069
(214) 491-6365

PATIENT INFORMATION			
Name: LAST	FIRST	M.I.	**Gender** Male ☐ Female ☐
Date of Birth / /	**Social Security Number:**		
Address:	**City**:	**State**:	**Zip Code**:
Home Phone ( ) -	**Alternate Phone** ( ) -		
Marital Status: __ Married __ Single __ Divorced ___ Widowed __ Other	**Race:** White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Decline to specify ☐		
Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify ☐	**Primary Language: _____**		
Email Address:	**Prefer Messages:** Phone call ☐ Text ☐ Email ☐		
Primary Care Physician (PCP):			

PRIMARY INSURANCE & SUBSCRIBER INFORMATION			
Primary Insurance Name:	**Relationship to Subscriber:**		
Subscriber's Name: LAST FIRST M.I.	**Subscriber's Date of Birth** / /		
Subscriber ID #	**Group #**	**Effective Dt:**	

SECONDARY INSURANCE			
Secondary Insurance Name:	**Relationship to Subscriber:**		
Subscriber's Name: LAST FIRST M.I.	**Subscriber's Date of Birth** / /		
Subscriber ID #	**Group #**	**Effective Dt**	

TERTIARY INSURANCE			
Tertiary Insurance Name:	**Relationship to Subscriber:**		
Subscriber's Name: LAST FIRST M.I.	**Subscriber's Date of Birth** / /		
Subscriber ID #	**Group #**	**Effective Dt:**	

Declaration: I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or not accurate or misrepresenting, I am aware that I may be held liable for it. I hereby authorize sharing of the information furnished on this form with other doctors or medical institutions for medical data. I further authorize the Cardiovascular Wellness Centers to make payment, any sum due to me, as per office/insurance claim process for the services provided.

_____ _____

Patient, Parent or Guardian's Signature **Date**