Methodist Cardiovascular Consultants

PATIENT INFORMATION

Name			Date of Birth	Sex ○ M ○ F
Address	City		State	Zip
Phone Home	Work		Cell	
Emergency Contact Name	Relationship		Phone	
Email Address	**Social Security Number**		Marital Status ○ Single ○ Married ○ Divorced ○ Widow	
Employer Name/Address			Student Status ○ Full Time ○ Part Time ○ Not a Student	
Race ○ Black/African American ○ Asian ○ Caucasian ○ Hispanic or Latino ○ Other (*Please Specify:)*				
Ethnicity ○ Hispanic or Latino ○ Not Hispanic ○ Decline to Provide				
Primary Language Spoken in the Home ○ English ○ Spanish ○ Other (please define):			Veteran ○ Yes ○ No Smoker ○ Yes ○ No	

RESPONSIBLE PARTY/GUARANTOR INFORMATION IF DIFFERENT FROM ABOVE

Name	Date of Birth	Relationship to Patient	
Address	City	State	Zip
Phone Home/Cell	Work	**Social Security #:**	

In order to better serve you, please provide information below on your current medical professionals. Please indicate if you would like copies of your medical records sent to these professionals listed.

	Release Records:
Primary Care Physician: ______________________	○ Yes ○ No
Specialist 1: ______________________	○ Yes ○ No
Specialist 2: ______________________	○ Yes ○ No

______________________ ______________

Signature of Patient or Legal Representative **Date**