CARDIOVASCULAR HEALTH CLINIC
ADVANCED INTERVENTIONAL RADIOLOGY SOLUTIONS
3200 Quail Springs Parkway, Ste. 200
Oklahoma City, OK 73134
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(F) 405-701-9881
cvhealthclinic.com

PLEASE PRINT: Use black or blue ink only

PATIENT INFORMATION

If this is work related, stop and notify receptionist

DATE:	Referring Physician & Phone Number:		Family Physician & Phone Number:	
LEGAL NAME	Last:	Suffix:	First:	Middle:
	Preferred Name:		Gender: ☐ Male ☐ Female	
Address:		City:	State:	Zip:
Birthdate: / /	Age:	Social Security # - -		
Home Telephone: ( )	Cell Phone: ( )		Work Phone & Ext: ( )	
Email:	May we contact you through Email: ☐ Yes ☐ No		Marital Status: ☐ S ☐ M ☐ W ☐ D	

Race:	**Ethnicity:**	**Religion:**	**Language:**	**Interpreter Needed:**
☐ Caucasian ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ Other ☐ Pacific Islander	☐ Hispanic or Latino ☐ Non-Hispanic ☐ Non-Latino		☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No

Employer:	Address:	City:	State:	Zip:

Employment Status: ☐ Full-time ☐ Full-Time Student ☐ Un-Employed ☐ Military ☐ Self-Employed ☐ Retired

Patient's Primary Contact (Not living in the same residence)	Contact Number: ( )	Relationship to Patient:

SPOUSE/PARENT INFORMATION

Spouse/Parent Information (if child under 18)	Relation to Patient:	Home Telephone: ( )	Cell Phone: ( )

Employment Status: ☐ Full-time ☐ Full-Time Student ☐ Un-Employed ☐ Military ☐ Self-Employed ☐ Retired

Employer:	Social Security # - -	Birthdate: / /	Age:	Work Phone & Ext: ( )
Address:	City:	State:	Zip:	

INSURANCE INFORMATION (Provide cards to copy)

Primary Insurance:			**Insurance Type:** ☐ Group ☐ Individual ☐ Cobra
Insured's Name on Card:	I.D. #	Group #	
Insured's Birthdate: / /	Patient's Relation to Insured:	Insured's Gender: ☐ Male ☐ Female	Insured's SS # / /

Secondary Insurance:			**Insurance Type:** ☐ Group ☐ Individual ☐ Cobra
Insured's Name on Card:	I.D. #	Group #	
Insured's Birthdate: / /	Patient's Relation to Insured:	Insured's Gender: ☐ Male ☐ Female	Insured's SS # / /

HOW DID YOU HEAR ABOUT US?

☐ Physician Referral ☐ Family/Friend ☐ Radio ☐ Social Media ☐ Billboard ☐ Google Search ☐ Health Fair ☐ Other:_____

I authorize the release of information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims made payable to Cardiovascular Health Clinic. I understand I am financially responsible for any changes not covered by my insurance.

_____ _____

Patient or Authorized Person Date