Frank Rubalcava, M.D. **Ted Trusevich, M.D.** **Yasser Farra, D.O.**
Charles Bailey, M.D. **Sheri Boyd, M.D.**
Prasantha Bathini M.D. **Ronnie Garcia, M.D.**
Melanie Morris, R.N., FNP-BC

PLEASE PRINT

PATIENT INFORMATION Primary Care Physician:_____
Today's Date:_____ Referring Doctor (If different from above:_____
Patient Name:_____ o Male o Female
Last, First, M.I.
Street Address:_____
Street/P.O. Box City State Zip Code
Mailing Address:_____
(If different from above) Street/P.O. Box City State Zip Code
Date of Birth: _____Age:____ Marital Status: o S o M o D Drivers License #_____
Social Security#:_____ Home Phone#:_____
Occupation:_____ Work Phone#:_____
Employer:_____Employer Address:_____

Spouse or Name of Parent: _____DOB _____Social Security #:_____
(circle one)
Employer:_____Home/Work Phone#:_____

EMERGENCY CONTACT NOT RESIDING WITH YOU
Name:_____ Relationship:_____
Address:_____
Street/P.O. Box City State Zip Code
Home Phone #:_____ Work Phone#:_____

INSURANCE INFORMATION (Please present all insurance cards and photo I.D. to receptionist)
Payment is expected at the time services are rendered unless other arrangements have been made. If you do not have any health insurance you must speak with the business office prior to leaving. We currently accept cash, checks and credit cards.

Primary Insurance Name:_____Secondary Insurance Name:_____
Policy ID#:_____ Policy ID #:_____
Group #:_____ Group#:_____
Policy Holder:_____Policy Holder:_____

- OR -

Personal Responsible for Bill:_____Relationship:_____
Address:_____
Street/P.O. Box City State Zip Code

I request and authorize that payment of authorized Medicare/Insurance benefits furnished to me be made payable to the physician or physicians and/or New Braunfels Cardiology. I authorize release of any medical information necessary to obtain payment of insurance benefits. I also understand that I am financially responsible for any balance not covered by my insurance and that a copy of this signature is as valid as the original.
Signature:_____ **Date**:_____

I have reviewed the HIPPA Notice of Privacy Practices from NBC Dated March 2003

Print Name:_____

Signature:_____

Date:_____