Comprehensive Cardiovascular Center
Vein Center
Sleep Medicine Clinic
5413 Crenshaw Rd., Suite 400 Pasadena, TX 77505
Office 713-943-2800 Fax 713-943-2801

Karan Bhalla, MD Amita Bhalla, MD Kaushal Patel, MD Angela Shiue, MD Benjamin Metz, DO

Patient Registration From

Last name:_____ First name:_____ M.I._____

Address:_____ City, ST_____

Zip code:_____ DOB:____/_____/_____ SSN:__ __ __-__ __-__ __ __ __ Gender: _____

Hm/Cell#_____ Work#_____email:_____

Referred by:_____ PCP:_____

Employer Information

Employer name:_____ Occupation:_____

Address: _____ City, ST _____ Zip_____

Insurance Information (Primary)

Carrier: _____ ID# _____ Group#_____

Insured: _____ DOB of Insured: _____

Insurance Information (Secondary)

Carrier: _____ ID# _____ Group#_____

Insured: _____ DOB of Insured: _____ Rel to insured: _____

Emergency Contact

Name:_____ PH#_____Relation:_____

Authorization/Disclosure

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize *Orion Medical* to apply for benefits on my behalf for covered services rendered by him/her. I request that payment from my insurance company be made directly to *Orion Medical*. I also authorize consent for treatment for any and all medical services performed. The authorization may be revoked by either me or my insurance carrier at any time in writing.
Date:_____ Signature: _____