



**SUGAR LAND HEART CENTER**

S.G. NIKAM, MD, FACC, FACP

*Clinical Associate Professor, Baylor College of Medicine*

**PATIENT INFORMATION**

NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_ SEX \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ SS# \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

INSURED EMPLOYER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**PRIMARY PHYSICIAN:** \_\_\_\_\_

**REASON For REFFERAL:** \_\_\_\_\_

**INSURANCE :**        **HMO** or **PPO** (Circle one)

**AUTHORIZATION:** \_\_\_\_\_

**INSURANCE NAME** \_\_\_\_\_

INSURED NAME \_\_\_\_\_ PT .REL \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

D.O.B \_\_\_\_\_ SEX \_\_\_\_\_ SS# \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

I hereby authorize Dr. Nikam to perform a physical examination on me, including tests to determine the state of my health. I authorize the release of any medical information that is necessary to process this claim. I also authorize payment of medical benefits directly to the physician. Your payment or Co-Pay is due at the time of service.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_