Phone: (832)-831-6932 Fax:(832)-831-6987 www.cardiacspecialistsofhouston.com

CARDIAC SPECIALISTS OF HOUSTON, PLLC
MASROOR A KHAN, MD, FACC, FSCAI
Diagnostic and Interventional Cardiologist
6550 Fannin St. Suite 2405, Houston, TX 77030

Today's Date:	**Primary Care Doctor's Name/Phone#:**

PATIENT INFORMATION

Last Name:	**First:**	**Middle:**

Are you diabetic? ○ Yes ○ No	**High Blood Pressure?** ○ Yes ○ No	**Email:**	**Birth date:**	**Age:**	**Sex:**

Address:

Social Security Number:	**Home phone number:**	**Cell phone number:**
Occupation:	**Employer:** **Employer Phone #:**	**Tobacco Use? (circle which applies)** Never Past Smoker Still Smoke_____ PPD

Chose clinic because/referred to clinic by (Please choose one option):
○ Referred by _____ Found Online
○ Hospital follow up Other

Pharmacy Phone Number:

ADDITIONAL INFORMATION

Allergies:

Medications: **Strength** **Times a day**

1)_____ _____mg _____
2)_____ _____ mg _____
3)_____ _____mg _____
4)_____ _____mg _____
5)_____ _____ mg _____
6)_____ _____mg _____
7)_____ _____mg _____

Major Medical Problems/Surgeries?

Family History:
Father: Alive Deceased
Cause of Death_____
Mother: Alive Deceased
Cause of Death_____

Family History of any of the following?
(circle all that apply)
Coronary artery disease
Heart attack
High Blood Pressure
High Cholesterol
Diabetes
Sudden death at early age

Other family members seen here:				
Main Health Concerns:	**Children:**	**Weight:**	**Alcohol:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Insurance Company:	**Secondary Insurance Company:**
Name of Insured: POLICY #: GROUP #:	POLICY #: GROUP #: Name of Insured (if different from previous):

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient:**	**Cell Phone #:** **Home Phone #:**

The above information is true to the best of my knowledge.

I hereby authorize Masroor A. Khan MD or associates to examine and treat me. I also authorize to release to my Insurance Company any information acquired in the course of my examination or treatment. I hereby authorize payment directly to Masroor A. Khan MD for surgical and/or medical benefits otherwise payable to me for services rendered. If benefits are payable to me, I authorize my Insurance Company or Medicare or Medicaid to furnish to my doctor any information in the adjudication of any claims in regards to services furnished to me. I hereby authorize the use of a photographic reproduction of this authorization in place of the original. I also understand that in case of electronic transmittal of claims to my Insurance Company the notation "Signature on record" will be used. This authorization is valid till I or my legally designated representative revokes it in writing.

_____ _____

Patient signature **Date**