Arlington Surgery

902 West Randol Mill Road, Suite 200
Arlington, Texas 76012
817-461-8327

Patient Information >

Whom are you here to see ___ James F. Norcross, MD ___ Baron L. Hamman, MD

Name _____ Social Security _____-_____-_____

Address _____ City _____ State _____ Zip _____

Phone – Home (____)_____ Work (____)_____ Cell (____)_____

__ Married __ Single __ Widow __ Divorced Age ____ Date of Birth _____ __ Male __Female

Race _____ Language _____ Ethnicity _____

Employer Name & Address _____

__ Full Time __ Part Time __ Retired __ Self Employed __ Student FT __ Student PT

Primary Care _____ Phone (____)_____

Cardiologist (heart) _____ Phone (____)_____

Pulmonologist (lung) _____ Phone (____)_____

Oncologist (cancer) _____ Phone (____)_____

Gastroenterologist (stomach) _____ Phone (____)_____

Insured Name (If no insurance, responsible party) >

Name _____ Relationship _____

Social Security _____-_____-_____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone – Home (____)_____ Work (____)_____ Cell (____)_____

Employer Name & Address _____

Notify in Case of Emergency (Please include these individuals on the HIPPA form) >

Name _____ Relation _____ H(___)_____ C(___)_____ W(___)_____

Name _____ Relation _____ H(___)_____ C(___)_____ W(___)_____

Name _____ Relation _____ H(___)_____ C(___)_____ W(___)_____

Insurance Information (Copies of Insurance Cards and Drivers License are required) >

Primary Insurance _____ Phone (____)_____

Policy _____ Group _____

Secondary Insurance _____ Phone (____)_____

Policy _____ Group _____

Authorizations >

For and in consideration of the services rendered by HeartPlace, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible, co-payment & coinsurance charges not covered by my insurance policy & charges not covered as a result of any law settlements or judgments obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by insurance policy, to include, charges for services deemed experimental, investigational &/or not medically necessary as determined by my insurance company.

Patients Signature _____ Date _____-20___