2726 Matlock Rd. Suite C
Arlington, Texas 76015
(817) 275-8991

24 Hr. Answering Service (817) 277-1861

M.C.M Medical Plaza
929 W. Pioneer Pkwy, Suite C
Grand Prairie, Texas 75051
(972) 606-2111

A. R. SALEEMI M.D., F.A.C.C., F.S.C.A.I.

Cardiology

Diplomate American Board
Cardiovascular Disease and Interventional Cardiology

Patient's Name: _____
First Middle Last

Home Address: _____
Number Street Apt # City State Zip

Employer: _____
Name Street Address City State Zip

Home Phone # _____ Work Phone # _____ Occupation _____

Sex: _____ Date of Birth: _____ Age: _____ Social Security # _____

Driver's License # _____ ( ) Married ( ) Divorced ( ) Single ( ) Widow/Widower

Number of Children _____

Spouse's Name: _____ Address if Different _____

Social Security # _____ D.O.B _____ Work Phone # _____

Spouse Employer: _____

Referred By: ( ) Phone Book ( ) Physician: _____

( ) PPO Directory ( ) Other: _____

Patient Pharmacy _____ Phone # _____

Emergency Contact Person _____
Name Street Address City State Zip

Phone _____ Relationship _____

Patient's Allergies _____

If Your Have Your Insurance Card We Will Make A Copy and You can skip the Next Section

	Primary Insurance	*Secondary Insurance*
Insurance Company:	_____	_____
Name of Policy Holder:	_____	_____
Policy #	_____	_____
Group #	_____	_____
Is this a PPO or an HMO	___ Yes ____ No	____ Yes ____ No

Authorization # _____

I authorize the release of any medical information necessary to process insurance claims by mail or electronic transmission. I further understand that payment is expected at the time services are rendered. The Patient, NOT THE INSURANCE COMPANY, is responsible for payment and obtaining any authorizations necessary. A Statement will be provided as a convenience to assist you in obtaining reimbursement for covered expenses from your insurance company. We cannot accept responsibility for collecting your insurance claim of for covered expenses or for negotiating a settlement disputed claim. I authorize my insurance company to make payment directly to TCRS. Please read the reverse side for important information.

Patient Signature: _____ **Date:** _____

I authorize the release of any medical information to my _____
Relationship Name

Patient Signature: _____ **Date** _____