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New Patient Information

Last Name: \_\_\_\_\_ First name: \_\_\_\_\_ M I: \_\_\_\_\_

SSN#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Spouse's Work Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Purpose of Visit: \_\_\_\_\_

Who referred you: \_\_\_\_\_

Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_



I authorize any policy holder of medical or other information about me to release to the social security administration and health care financing administration or its intermediaries, any insurance company and any information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits and other insurance companies apply.

My signature below constitutes that I have answered to the best of my ability all of the above questions, and I understand that I am responsible for all cost not covered by my insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **PRIVACY PRACTICES ACKNOWLEDGEMENT**

**I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.**

Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_