PATIENT INFORMATION

Last Name _____First_____ MI _____ Social Security # _____

Mailing Address _____ Home Phone (_____) _____

City _____ County _____ State _____ Zip _____

Birthdate _____ Age _____ [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Patient employed by _____ Job Title _____

Business Address _____ City _____ TX ZIP _____

Business Phone (_____) _____ Cell/Pager (_____) _____

In case of Emergency, who should be notified? _____ Phone (_____)_____

Who may we thank for referring you? _____

Who is your primary care physician? _____

PRIMARY INSURANCE

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____SSN _____

Address (if different from Patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person responsible Employed by _____ Job Title _____

Business Address _____ Business Phone (_____)_____

City _____ State _____ Zip _____

INSURANCE COMPANY _____

Group # _____ **ID #** _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

********** **Is patient covered by additional insurance? [ ] Yes [ ] No** **********

Subscriber Name _____ Relation to Patient _____ DOB _____

Address (if different from Patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Insurance Company _____ SSN _____

Group # _____ ID # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I(or my dependent) have insurance coverage with the above listed company, and assign directly to the physician/s all insurance benefits, if any, otherwise payable to me for services rendered**. I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Date _____ Signature _____

THIS FORM MUST BE FILLED OUT COMPLETELY