Dallas Medical

Doctors of Internal Medicine

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PATIENT INFORMATION:

Please print clearly and fill out completely: **Primary Care Physician**_____ **Referred By**_____

Name_____
First Middle Last

Address_____
Street Apt City State Zip

Home Phone (___)_____ **Work Phone (___)**_____ **Mobile (___)**_____ **Beeper (___)**_____

Date of Birth ___/___/_____ **Age** ____ **Social Security#**_____ **Driver License**_____ **State**_____

Name of Employer_____ **Phone# (___)**_____

Address_____ **City**_____ **State**_____

Martial Status_____ **Spouse/Significant Other's Name** _____ **Date of Birth** ___/___/____

Primary Insurance Information

Name of Insurance_____

Insurance Address for Claims_____ **City**_____ **State**____ **Zip**_____

Name of Insured_____ **Relationship to Patient**_____

Insured's Information:

Date of Birth ___/___/_____ **Insured's Social Security#** _____ **Member#**_____ **Group#**_____

Insured's Employer_____ **Phone# (___)**_____

Insured's Employer Address_____ **City**_____ **State**_____ **Zip**_____

Secondary Insurance Information

Name of Insurance_____

Insurance Address for Claims_____ **City**_____ **State**____ **Zip**_____

Name of Insured_____ **Relationship to Patient**_____

Insured's Information:

Date of Birth ___/___/_____ **Insured's Social Security#** _____ **Member#**_____ **Group#**_____

Insured's Employer_____ **Phone# (___)**_____

Insured's Employer Address_____ **City**_____ **State**_____ **Zip**_____

Nearest Friend or Relative Not Living With You (in case of emergency)

Name_____ **Relationship to Patient**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone (___)_____ **Business Phone(___)**_____ **Mobile(___)**_____ **Beeper(____)**_____

I hereby assign to Dallas Medical any money payable to me under hospitalization or other insurance coverage, and/or arrangements with their parties, for payment of such services. I authorize Dallas Medical to furnish my insurance company the medical information requested. I agree to be responsible for any testing or treatment that may not be considered by my insurance company, to be medically necessary. I also agree to pay Dallas Medical $60.00 for no show appointments if not properly cancelled within 24 hours prior to the scheduled appointment.

Signature_____ **Date**___/___/_____ **Account#** _____