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#** _____