DFW
INTERNAL MEDICINE
CLINIC
Expert in Adult Health Care

Today's Date:

PATIENT DEMOGRAPHIC INFORMATION

Patient's last name: | First: | Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Email: | SSN: | DOB: | Sex: ☐ M ☐ F

Street Address:

City: | State: | ZIP Code: | Home Phone:

Driver's License (DL)#: | DL State: | Cell Phone:

Are you Employed? Yes☐ No ☐ Full-Time ☐ Part-Time☐ Self-Employed☐ Retired☐

Employer: | Position: | Work Phone:

Chose clinic because/referred to clinic by (Please check one box): ☐ Dr. | ☐ Insurance plan | ☐ Hospital

☐ Family | ☐ Friend | ☐ Close to home/work | ☐ Yellow Pages | ☐ Other

Other family members seen here:

Reason for today's visit:

PRIMARY INSURANCE INFORMATION

(Please give your insurance card at each visit to the receptionist)

Insurance Company Name: | Policy #: | Group #:

Deductible Amount: | Co-pay amount or %: | Current PCP: | PCP Phone:

Claims Mailing Address:

Primary Insured: | Insured DOB: | Insured SS#:

Insured Employer: | Employer Phone No:

Is this patient covered by insurance? ☐ Yes ☐ No

Subscriber's name: | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment:

SECONDARY INSURANCE INFORMATION

(Please give your insurance card at each visit to the receptionist)

Insurance Company Name: | Policy #: | Group #:

Deductible Amount: | Co-pay amount or %: | Current PCP: | PCP Phone:

Claims Mailing Address:

Primary Insured: | Insured DOB: | Insured SS#:

Insured Employer: | Employer Phone: | Insured Phone:

Is this patient covered by insurance? ☐ Yes ☐ No | Insured Relationship to Patient:

Subscriber's name: | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment:

EMERGENCY CONTACT

Emergency Contact Person: | Relationship to Patient: | Home Phone: | Cell or Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I acknowledge that I am responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier.

_____ _____

Signature of Patient or Authorized Representative | ***Date***

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