862 W Rusk Street
Rockwall, Texas 75087
972-412-3034

757 East US Hwy 80, Suite 200
Forney, TX 75126
972-646-3346

Date: / /

Please Print

Patient Information

PATIENT'S NAME	GENDER:	BIRTHDATE:	PHONE:
ADDRESS: (NUMBER & STREET)	CITY:	STATE:	ZIP:
ADULT(S) RESPONSIBLE (NAME) / Custody arrangement if divorced /separated:	E-MAIL		

BROTHERS / SISTERS:	BIRTHDATE:	HEALTH:
(1)		
(2)		
(3)		
(4)		
(5)		

IN CASE OF EMERGENCY NOTIFY:	RELATIONSHIP:	PHONE:	ADDRESS:

Family History Information

PARENT /GUARDIAN:		OTHER PARENT /GUARDIAN:	
ADDRESS		ADDRESS	
BIRTHDATE:	S.S.# :	BIRTHDATE:	S.S.# :
DRIVER'S LICENSE # :		DRIVER'S LICENSE # :	
EMPLOYED BY:		EMPLOYED BY:	
WORK PHONE:	CELL PHONE:	WORK PHONE:	CELL PHONE:
REFERRED BY:		PREFERRED CONTACT EMAIL:	
PRIMARY PHARMACY & LOCATION:		PREFERRED CONTACT PHONE:	

NOTE: An Insurance card is required at all office visits.

I authorize the physician to release medical information that my be necessary to request reimbursement from insurance companies to whom I have submitted a claim.

I assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to the physician. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not paid by insurance (commercial or Medicaid). I understand that any overpayment on my account will be promptly refunded.

I voluntarily consent to medical treatment and understand that no guarantees are made as to the results.

Patient's Name: ______________________________________ Date: ____________

Signature: ______________________________________ ☐ Parent ☐ Guardian