Texas Internists Registration Form

PATIENT INFORMATION

☐ Please Circle: Mr. Mrs. Ms. Jr. Sr. Other_____

Patient's Name (Last) _____ (First) _____

(Middle)_____ Also Known As Name_____

Social Security Number_____-____-_____ Female Male Date of Birth_____/_____/_____

Marital Status _____ Dominant Hand _____ Language Preferred _____

E-mail Address_____

Phone Numbers Work_____ Home_____

Cellular_____ Pager_____

Address_____

City, State, Zip (+4) _____

Employer_____ Phone Number_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____ Phone Number_____

INSURED PARTY INFORMATION (if different from patient information)

Insured Party Name (Last) _____ (First) _____

Social Security Number_____-____-_____ Date of Birth_____/_____/_____

Phone Numbers Home_____ Work_____

PREFERRED PHARMACY

Pharmacy Name _____Phone Number _____

Address _____Zip Code_____

WHOM TO CONTACT

I hereby give permission to Texas Internists to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name_____Relationship_____Phone Number_____

Name_____Relationship_____Phone Number_____

Name_____Relationship_____Phone Number_____

☐ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

I wish to be contacted in the following manner: Home #:_____Work #:_____ Cell#_____

☐ OK to leave message with detailed information on cell
☐ OK to leave message with detailed information at home
☐ OK to leave message with call back number only at home
☐ OK to leave message with detailed information at work
☐ OK to leave message with call back number only at work
☐ Written communication
☐ OK to mail to my home address:_____
☐ OK to mail to my work/office address:_____
☐ OK to fax to this number:_____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of Patient or Legal Representative_____ Date_____