

PATIENT INFORMATION



Today's Date: _____

First Name _____ Last Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home # () _____ Cell # () _____ Work # () _____

Social Security Number _____ - _____ - _____

Email address (optional) _____

HOW DID YOUR HEAR ABOUT US?

Family	Friend	TV/Radio	Yellow Pages	Physician	Newspaper	Other
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PHYSICIAN HISTORY

Primary Care Physician _____ Phone # _____

Specialty Physician _____ Phone # _____

Specialty Physician _____ Phone # _____

INSURANCE INFORMATION

Primary _____	Secondary _____
Policy# _____	Policy# _____
Group# _____	Group# _____
Address _____	Address _____
City, State Zip _____	City, State Zip _____
Insured Name _____	Insured Name _____
Relationship _____	Relationship _____
Effective Date _____	Effective Date _____
Co-Payment _____	Co-Payment _____
Deductible \$ _____ Family or Individual	Deductible \$ _____ Family or Individual
Has deductible been met? _____	Has deductible been met? _____
In-Network or Out-of-Network _____	In-Network or Out-of-Network _____
Notes: _____	Notes: _____

I hereby authorize Methodist Healthcare Health for Life Center to bill my insurance for any services rendered to me. I agree to be responsible for any services that may not be covered under my benefit plan. Payment is due at the time services are rendered.

Signature _____ Date _____