Confidential Patient Information

❑ Medical ❑ WMC ❑ Auto ❑ IMM

Please Print ***Please provide accurate telephone numbers so we may provide excellent medical care.*** *Entered by* _____ *A/C#* _____

PATIENT'S NAME LAST	FIRST	MIDDLE	NICKNAME	DATE

ADDRESS: NO. & STREET	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	PREFERRED TELEPHONE # TO CALL & LEAVE MESSAGE	AGE	BIRTHDATE	SEX
		❑ CELL ❑ HOME ❑ OTHER_____			❑ Male ❑ Female

SPOUSE'S CELL PHONE	EMAIL ADDRESS	NEIGHBOR'S PHONE Name:	DRIVER'S LICENSE

MARITAL STATUS ❑ Single ❑ Married ❑ Widowed ❑ Divorced	SOCIAL SECURITY NO.	EMERGENCY CONTACT: Relation: ( )

EMPLOYER / SCHOOL	BUSINESS PHONE ( ) ext.	OCCUPATION	REFERRED BY

EMPLOYER'S ADDRESS NO. & STREET	CITY	STATE	ZIP

PERSON RESPONSIBLE FOR PAYMENT

NAME LAST	FIRST	MIDDLE	SOCIAL SECURITY NO.	D. O. B.

ADDRESS: NO. & STREET	CITY	STATE	ZIP	HOME PHONE ( )

EMPLOYER	OCCUPATION	DRIVER'S LICENSE NO.

EMPLOYER'S ADDRESS: NO. & STREET	CITY	STATE	ZIP	BUSINESS PHONE EXT. ( )

RELATIONSHIP TO PATIENT

Primary insurance:

INSURANCE INFORMATION

INSURANCE COMPANY	INSURED'S NAME	D.O.B.

ADDRESS FOR CLAIMS: NO. & STREET	CITY	STATE	ZIP	SOCIAL SECURITY NO.

POLICY NO.	GROUP NO.	CERTIFICATE NO.

AMOUNT OF DEDUCTIBLE	AMOUNT OF CO-INSURANCE	CO-PAY

Secondary insurance:

INSURANCE INFORMATION

INSURANCE COMPANY	INSURED'S NAME	D.O.B.

ADDRESS FOR CLAIMS: NO. & STREET	CITY	STATE	ZIP	SOCIAL SECURITY NO.

POLICY NO.	GROUP NO.	CERTIFICATE NO.

AMOUNT OF DEDUCTIBLE	AMOUNT OF CO-INSURANCE	CO-PAY

PT . Account # _____ Entered By _____ Date Entered _____

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine and conduct of laboratory, X-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate.

I acknowledge full responsibility for the payment of such services and agree to pay them in full AT THE TIME OF SERVICES unless other arrangements are made with the Financial Department. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Medinet Family Care Clinic will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a resonable period of time.

I authorize Medinet Family Care Clinic to release information as required to my insurance or third-party payor (including my employer or my employer's worker's compensation carrier), for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues. I also authorize Medinet Family Care Clinic to bill my insurance or third-party payor and receive payment directly from them for services rendered.

This authorization shall remain valid for a period of two (2) years or until such time as I revoke it in writing. A photocopy or a telefaxed copy of this authorization shall be deemed as valid as the original.

Signed: Patient, Parent of Guardian _____ Date _____

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licenses and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners
Attention: Investigations
1812 Centre Creek Drive, Suite 300
P.O. Box 149134
Austin, Texas 78714-9134

Medinet Family Care Clinic

❑ 9130 Hwy. 6 So. • Houston, TX 77083
Tel: (281) 564-3300 • Fax: (281) 564-2777