PATIENT INFORMATION

(PLEASE PRINT)

LAST NAME		FIRST NAME	MI
BIRTH DATE	AGE	SS#	TX DRIVERS LICENSE #

STREET ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)			

HOME PHONE #	CELL PHONE #	E-MAIL	MARITAL STATUS (circle one) Married Single Divorced Widowed

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE #
ADDRESS		

PHARMACY INFORMATION

PREFFERED PHARMACY	PHONE #
ADDRESS	

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	PROVIDER SERVICES #
ID #	GROUP #

PLAN HOLDER	RELATIONSHIP TO INSURED	DOB

SECONDARY INSURANCE NAME	PROVIDER SERVICES #
ID #	GROUP #

PLAN HOLDER	RELATIONSHIP TO INSURED	DOB

OTHER INFORMATION

REFERRED BY:	PHONE #	RELATIONSHIP
EMPLOYED BY:	OCCUPATION	WORK #
RESPONSIBLE PARTY (If Minor, under 18yrs old)	RELATIONSHIP	PHONE #

All professional services rendered are charged to the patient. The patient is responsible for payment of doctor's fees within 30 days regardless of insurance coverage or status of insurance clam(s). Extension of credit beyond 30 days must be discussed and approved by the business office in advance. All payments received will be applied to your account balance or credited to your account. Necessary forms will be completed and forwarded to the above insurance companies in order to expedite insurance carrier payments. Any paperwork needing to be completed by a physician (FMLA, Disability, etc) will be assessed a fee of $25 per form.

INSURANCE AUTHORIZATION AND ASSIGNMENT (please read & sign)
I hereby authorize **C. FUNSHO FAGBOHUN, MD, PhD, P.A.** to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the physician(s) all payments for medical services rendered to me or my dependents. I understand that I am responsible for all charges regardless of insurance coverage.

SIGNATURE: ____ DATE: ________________________