

Dallas Medical Specialists Registration Form

PATIENT INFORMATION

Please Circle: Mr. Mrs. Ms. Jr. Sr. Other _____
Patient's Name (Last) _____ (First) _____
(Middle) _____ Also Known As Name _____
 Please Circle: Married Single Divorced Widowed Separated Ethnicity: _____
Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/_____
E-mail Address _____
Phone Numbers Daytime _____ Evening _____
Cellular _____ Pager _____
Address _____
City, State, Zip(+4) _____
Employment Status Please circle: Employed Retired Self Employed Unemployed
Full-time Student Part-time Student

Employer _____ Phone Number _____
Emergency Contact Name _____ Phone Number _____
Emergency Contact Relationship to Patient _____
Referring Provider Name _____ Phone Number _____

INSURED PARTY INFORMATION

Insured Party Name (Last) _____ (First) _____
Social Security Number _____ - _____ - _____ Date Of Birth ____/____/_____
Phone Numbers Home _____ Work _____

Primary INSURANCE NAME _____
Insurance Phone Number _____

Secondary Insurance
Name _____
Secondary Phone Number _____

I. Whom to contact

I hereby give permission to Dallas Medical Specialists 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 #: _____

- 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 _____