

TAYLOR TEXAS MEDICINE

PATIENT INFORMATION

PLEASE PRINT

Name Social Security# Age
(Last Name, First Name, MI)
Address City State ZIP
Birthdate Home Phone CellPhone
Sex: M F Marital Status: Single Married Widowed Divorced Other
Patient Employed by Occupation
Business Address City State ZIP
Employment Status: Full-Time Part-Time Retired NotEmployed Student
Business Phone

Person to Notify In Case of Emergency

Name: Relationship Phone
Address City State ZIP

Primary Insurance

Subscriber Name
Relation Birthdate
Social Security#
Address
Home Phone
Subscriber Employer
Business Phone
Insurance Co.
Address
ID #:
Group #:

Additional Insurance

Subscriber Name
Relation Birthdate
Social Security#
Address
Home Phone
Subscriber Employer
Business Phone
Insurance Co.
Address
ID #:
Group #:

Assignment and Release

I, the undersigned, certify that my dependent or I have insurance coverage with (Name of Insurance Company) and assign Dr. Tad W. Taylor all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date