Texas Family Medicine
8380 Warren Parkway, Ste 100
Frisco, TX 75034

Patient Information

Mr. Mrs.
Miss Ms. ______________________________ ______________
(First, Middle, Last Name) *(Date of Birth)*

______________________________ ______________________________
(Address) *(City, State, Zip Code)*

______________ ______________ ______________
(Home Telephone Number) *(Work Telephone Number)* *(Cell Phone Number)*

______________ ______________ ______________
(Social Security Number) *(Nickname)* *(Prior Name)*

______________________ Would you like access to the patient portal? ☐ Yes ☐ No
(E-Mail Address)

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Sex: ☐Male ☐Female
Employment Status: ☐Employed ☐ Part-time Student ☐ Full-time Student ☐ Other
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race: ☐ Asian ☐ Black or African American ☐ Hispanic ☐Native Hawaiian or Other Pacific Islander
☐ White

Employment Information

______________________ ______________________________
(Occupation) *(Employer)*

______________________________ ______________________
(Address) *(City, State, Zip)*

Spouse Information

______________ ______________ ______________
(Name) *(Social Security Number)* *(Date of Birth)*

______________________ ______________________________
(Occupation) *(Employer)*

______________ ______________
(Cell Phone Number) *(Employer Phone Number)*

Responsible Person (If Applicable)

______________________________ ________ ______________
(Name) *(Date of Birth)* *(Relationship to Patient)*

______________________________ ______________________
(Address) *(City, State, Zip Code)*

______________ ______________ ______________
(Phone Number) *(Social Security Number)* *(Occupation)*

______________________________ ______________
(Employer) *(Employer Phone Number)*

Relative to Contact in Case of Emergency (Not Living in Home of Patient)

______________________________ (Name)
______________________________ (Phone Number)
______________________________ (Alternate Phone Number)

______________________________ (Address)
______________________________ (City, State, Zip Code)

Relation to patient: ______________________________

Insurance Information

______________________________ (Name of Insured)
______________________________ (Date of Birth)
______________________________ (Relationship to Patient)

______________________________ (Insurance Company)
______________________________ (Social Security Number)
______________________________ (Group Number)
______________________________ (ID Number)

______________________________ (Address)
______________________________ (City, State, Zip Code)

How were you referred to our office?

- ☐ By an Attorney
- ☐ By a Doctor
- ☐ By a Patient
- ☐ Other

Please print the name of your source below.

____

Is your illness or injury related to any of the following?

☐ Accident ☐ Auto Accident ☐ Emergency ☐ Employment

Which pharmacy do you use? ______________________________

Address: ______________________________

____

Phone: ______________________________

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment.

Financial Responsibility and Assignment of Benefits

I agree to pay all charges for medical and health care services not covered by my insurance company.

I certify that I have read this form and understand its contents.

______________________________ *(Patient or Other Legally Authorized Person)*

______________________________ *(Date)*