

# Texas MedClinic Patient Information Worksheet



Time in \_\_\_\_\_

Doctor: \_\_\_\_\_

## PATIENT INFORMATION

Reason for today's visit \_\_\_\_\_ Date of Injury \_\_\_\_\_

[ ] Mr. [ ] Mrs. [ ] Ms. [ ] Dr. Name \_\_\_\_\_ [ ] Sr. [ ] Jr.

Address \_\_\_\_\_ Apt \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Primary Phone # \_\_\_\_\_ Secondary Phone # \_\_\_\_\_  
 Home  Work  Cell  Home  Work  Cell

Date of Birth \_\_\_\_\_ Social Security #: \_\_\_\_\_  
*(If patient is less than 18 years old, please complete the guardian information below.)*

Marital Status [ ] Married [ ] Single [ ] Other \_\_\_\_\_ Sex [ ] Male [ ] Female

Are you a full time student? [ ] Yes [ ] No

Referring Physician \_\_\_\_\_

E-Mail Address \_\_\_\_\_

How did you hear about Texas MedClinic? \_\_\_\_\_  
*(Radio, Yellow Pages, Physician, etc.)*

Guardian / Guarantor (if other than patient): [ ] Patient same as Guarantor

[ ] Mr. [ ] Mrs. [ ] Ms. [ ] Dr. Name \_\_\_\_\_ [ ] Sr. [ ] Jr.

Address \_\_\_\_\_ Apt \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Primary Phone # \_\_\_\_\_ Secondary Phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Home  Work  Cell  Home  Work  Cell

Social Security Number \_\_\_\_\_ Patient's relationship to guarantor [ ] Spouse [ ] Child [ ] Other

## PAYMENT INFORMATION - PAYMENT IS EXPECTED AT TIME OF SERVICE

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cash  | <input type="checkbox"/> Check   | <input type="checkbox"/> Insurance (Please provide your insurance card to the receptionist, and review Texas MedClinic's Insurance Filing Policy.) |
| <input type="checkbox"/> Debit Card <i>(with Visa, MC logo only)</i> |  |  |
| <input type="checkbox"/> Credit Card <i>(Visa, MC, Discover)</i>     | <input type="checkbox"/> Medicare (Payment is required at time of service - See Insurance Filing Policy) |  |

## IF YOU WERE REFERRED TO TEXAS MEDCLINIC BY AN EMPLOYER, PLEASE COMPLETE THE FOLLOWING

Employer Name \_\_\_\_\_ Employer Telephone # \_\_\_\_\_  
*(if different from above)*  
 Store Number and/or Location \_\_\_\_\_

## INSURANCE INFORMATION - PLEASE BE PREPARED TO SHOW YOUR ID CARD

IF TEXAS MEDCLINIC WILL BE FILING A CLAIM WITH YOUR INSURANCE CARRIER, PLEASE COMPLETE THE FOLLOWING:

Insured I.D. Number \_\_\_\_\_ Insurance Company \_\_\_\_\_  
 Insured Employer/Group Name \_\_\_\_\_ Group # \_\_\_\_\_

*If insured is different than Guardian / Guarantor, please complete the following:*

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Insured's Address \_\_\_\_\_ Apt \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 Insured's Home Telephone # \_\_\_\_\_ Social Security# \_\_\_\_\_  
 Patient relationship to Insured [ ] Self [ ] Spouse [ ] Child [ ] Other

## Verification of Work Related Problem

Receptionist \_\_\_\_\_