

# 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.)*

HIPAA acknowledgement on File

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

Referring Physician \_\_\_\_\_ Would you like your record sent to your family doctor? [ ] Yes [ ] No  
 Family Doctor \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_

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

### Guardian / Guarantor (if other than patient):

[ ] 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 \_\_\_\_\_

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

- [ ] Cash [ ] Check [ ] Insurance (Please provide your insurance card to the receptionist, and review Texas MedClinic's Insurance Filing Policy.)
- [ ] Debit Card *(with Visa, MC logo only)*
- [ ] Credit Card *(Visa, MC, Discover)* [ ] 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 # \_\_\_\_\_

## Verification of Work-Related Problem

\_\_\_\_\_

Receptionist \_\_\_\_\_