

Tarpon, P.A.

P.O. Box 678595, Dallas, TX. 75267

\_\_\_ NEW PATIENT

\_\_\_ INFO CHANGE

DATE: \_\_\_\_\_ Reason for seeing physician: \_\_\_\_\_

**PATIENT INFORMATION**

(This information is regarding the person who is seeing the doctor)

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, & Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**If Worker's Comp, please state Employer where injury took place, full address and phone number**

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's Phone #: \_\_\_\_\_

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

Phone #: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Case Manager Phone: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

(If someone other than patient is responsible for the bill we will need the following)

Relationship to Patient:  Husband/Father  Wife/Mother  Other

Responsible Party Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, & Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**NEAREST RELATIVE INFORMATION**

(This information will be used when we are unable to contact the patient. For example: If your doctor is called out in an emergency and your appointment must be cancelled.)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, & Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Claim #: \_\_\_\_\_

**INSURANCE INFORMATION**

PLEASE CHECK ONE AND COMPLETE INFORMATION BELOW:

Private Insurance (Group): \_\_\_\_\_ Worker's Comp: \_\_\_\_\_ Auto Accident: \_\_\_\_\_ Individual: \_\_\_\_\_ Other: \_\_\_\_\_

Is this visit due to: Injury on the job? \_\_\_/\_\_\_/\_\_\_ date of injury Automobile accident \_\_\_/\_\_\_/\_\_\_ date of injury

Insurance Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ W.C. Adjustor: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Patient's Relationship to Policy Holder: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Insurance Authorization #: \_\_\_\_\_

**Secondary Insurance**

Insurance Company Name: \_\_\_\_\_  Group Insurance  Individual

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Patient's Relationship to Policy Holder: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

**Attorney Information**

Have you at this time engaged the services of an attorney in connection with your present illness?  Yes  No

If "Yes", who is the attorney: \_\_\_\_\_ Phone #: \_\_\_\_\_

If "No", do you anticipate retaining an attorney?  Yes  No

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the above-named agency to release any treatment information requested by attorneys, physicians, insurance companies, employers, health care providers or any other entity which may be concerned with the payment of charges incurred for the treatment services of Tarpon, P.A. and hereby authorize payment directly to Tarpon, P.A., for services rendered. I accept responsibility for payment of any charges not paid for or accepted by my insurance.

\_\_\_\_\_  
Date Patient (Parent or Guardian if minor)