EXPRESS MEDICAL
SERVICES

**Tel**: (281) 612-9990
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# PATIENT INFORMATION FORM

| Patient Name | | | Social Security Number |
|---|---|---|---|
| Date of Birth | Marital Status<br>S M D W P | Address | |
| Home Phone | Ok to leave message? Yes No | City | State / Zip Code |
| Email Address | | Employer's Name/Occupation | |
| Mobile Phone or Pager | | Work Phone | Ok to leave message? Yes No |
| Emergency Contact | Relationship | | Emergency Contact Phone |
| Primary Care Physician | | **Insurance**<br>Name of Insurance co. ______________________<br>ID# ______________________<br>Group# ______________________<br>Phone# ______________________ | |
| Pharmacy with two cross streets | | | |
| How were you referred to our practice?<br>☐ Newspaper ☐ Friend ☐ Internet<br>☐ Sign/Drive Bye ☐ Yellow pages ☐ Other_____________ | | | |

## Parent/Guardian or Primary Insured Info (if patient is a minor or is not the primary insured)

| Parent/Guardian or Primary Insured Name | | | Social Security Number |
|---|---|---|---|
| Date of Birth | Relationship to patient | Address *(if different from above)* | |
| Home Phone | | City | State / Zip Code |
| Work Phone | | Employer's Name | |

------------------------------------------------**Please read below and sign**------------------------------------------------

**Benefits Assignment**

I hereby authorize the assignment of benefits (payments) directly to Express Medical Services for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance

Signature of Responsible Party: ______________________________ Date: ___________________________

**Record Release**

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: ______________________________ Date: ___________________________