ENDOCRINE ASSOCIATES OF DALLAS, P.A. -- PATIENT INFORMATION AND CONSENT

REFERRING PHYSICIAN'S NAME_____**PHONE #** _____

MEDICAL REASON FOR REFERRAL_____

NAME OF PATIENT: _____
First **Middle** **Last**

HOME ADDRESS:_____**CITY:**_____**STATE/ZIP :** _____

PHONE #: Hm:_____**Wk:** _____**Cell:**_____

AGE:_____ **DATE OF BIRTH:**_____**SEX:**_____**SOCIAL SECURITY #:** _____

PARENT/LEGAL GUARDIAN NAME (if patient is a minor):_____

RELATIONSHIP TO PATIENT:_____**PHONE# Hm:**_____**Wk:**_____**Cell:**_____

HOME ADDRESS:_____**CITY:**_____**STATE/ZIP :**_____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____**RELATIONSHIP:**_____

PHONE #: Hm:_____**Wk:** _____**Cell:**_____

PATIENT'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____**CITY:**_____**STATE/ZIP:**_____

PATIENT'S MARITAL STATUS (CHECK ONE): ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED/SEPARATED**

SPOUSE'S NAME: _____**DATE OF BIRTH:** _____

SPOUSE'S EMPLOYER: _____**WORK PHONE:**_____

EMPLOYER ADDRESS:_____**CITY:**_____**STATE/ZIP:**_____

~ HEALTH INSURANCE INFORMATION~

Name of Insured:_____**Date of birth:**_____

Primary Insurance:_____**Member #:**_____**Group#:**_____

Coverage Verification Phone #:_____

Secondary Insurance:_____**Member #:**_____**Group#:**_____

Coverage Verification Phone #:_____

Any financial benefit that a patient may receive from insurance is a matter of settlement between that patient and the insurance carrier. Payment for services which we provide during a visit to our office is the legal responsibility of the patient or parent/legal guardian of a minor patient. Such payment is due at the time of office visit.

Please speak with our office staff if you have any questions.

CONSENT AND AUTHORIZATIONS:

I GRANT PERMISSION TO ENDOCRINE ASSOCIATES OF DALLAS, P.A. TO PERFORM ANY NECESSARY MEDICAL PROCEDURES AND TO ADMINISTER SUCH ANESTHETICS AND/OR DRUGS AS MAY BE REQUIRED FOR MEDICAL DIAGNOSIS AND/OR TREATMENT FOR MYSELF OR MINOR CHILDREN FOR WHOM I AM LEGALLY RESPONSIBLE.

I hereby authorize Endocrine Associates of Dallas, P.A. to release any information acquired in the course of my examination or treatment, or that of minor children for whom I am legally responsible, to referring physician(s) or to my healthcare insurance carrier or that of said minor children.

I hereby authorize any physician, hospital, or medical care facility to provide all information about my medical history and treatment, or that of minor children for whom I am legally responsible, to Endocrine Associates of Dallas, P.A.

I hereby authorize my health care insurance carrier and that of minor children for whom I am legally responsible to make payment directly to Endocrine Associates of Dallas, P.A. (Richard Sachson, MD, Steven Dorfman, MD, Stephen Aronoff, MD, Mitchell Sorbsy, MD, Audrey Miklius, MD, S K Lakhian, MD, Heidi Chamberlain Shea, MD) for medical and/or surgical benefits. If payment for these services is sent directly to me under the terms of the insurance benefits, I understand that I remain financially responsible to Endocrine Associates of Dallas, P.A., for the charges for my medical care or that of the aforementioned minor children. I further understand that I am responsible for charges not covered by the health care insurance carrier or by this authorization.

I hereby authorize photocopies of this document to be valid as the original.

_____ _____

(Adult Patient Signature) **(Date)**

_____ _____

(Signature of Parent/Legal Guardian of Minor Patient) **(Date)**