DIAGNOSTIC PARTNERS OF NORTH TEXAS

1600 Coit Rd, Ste 101, Plano TX 75075, Ph# 972-867-9507

Murphy Medical Clinic,

345 West FM 544, Ste 100, Murphy TX 75094

Ph # 972-578-7700 Fax # 972-578-7705

PATIENT REGISTRATION INFORMATION

Name _____ DOB _____ Soc. Sec # _____

Address _____ City _____ ST ___ Zip _____

Home phone _____ Cell phone _____

Email Address_____

Sex: □ M □ F □ Single □ Married □ Widowed □ Separated □ Divorced

Race _____ Ethnicity _____ Language_____

Occupation _____ Employer _____

Work Address _____ Work Phone_____May we call you at work? Y/N

How did you hear about us? _____ Reason for today's visit _____

INSURANCE INFORMATION

Primary Insurance Company_____

Primary Insured _____ Gender _____ DOB _____

SS# _____ Relationship: □ Self □ Spouse □ Child □ Other

Address (if different from patient) _____

Additional Insurance? Y/ N

Secondary Insurance Company_____

Primary Insured _____ Gender _____ DOB_____

SS# _____ Relationship: □ Self □ Spouse □ Child □ Other

Address (if different from patient) _____

PHARMACY INFORMATION

Pharmacy Name_____ Ph # _____Address _____

ASSIGNMENT AND RELEASE

I request that payment of authorized insurance benefits be made on my behalf to *Diagnostic Partners of North Texas/ Murphy Medical Clinic* for any services provided to me. I, on my behalf as well as on my dependent's behalf, authorize to release of any medical information to the insurance company needed to determine benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original until revoked in writing. **I understand that I am financially responsible for all charges whether or not covered by said insurance.**

Patient's Signature _____ Date _____

Guardian Signature _____ Relationship to the Patient _____