STEVEN C. DICKHAUT, M.D.
4800 NE STALLINGS DR.
SUITE 110
NACOGDOCHES, TX 75965

PATIENT INFORMATION

DATE: ________________

PATIENT'S NAME:___________________________________ AGE:________ SEX : M ( ) F ( )

DATE OF BIRTH:_________________ SOCIAL SECURITY #:___________________

ADDRESS: _____________________ ___________________ ______ ______
STREET CITY, STATE ZIP

HOME PHONE:___________________ CELL PHONE :_______________________________

CIRCLE MARITAL STATUS: **M S D W** EMAIL______________________________________

PHARMACY (To be used for Prescriptions):____

RACE____________________ ETHNICITY: HISPANIC NON HISPANIC LANGUAGE________________

PATIENT'S EMPLOYER INFORMATION

EMPLOYER:____ OCCUPATION:___________________

EMPLOYMENT STATUS: FULL TIME ( ) PART-TIME ( ) SELF ( ) RETIRED ( ) ACTIVE MILITARY ( )

EMPLOYER ADDRESS:____
Street City State Zip Code

PHONE :________________________ Extension:___________

PATIENT'S SPOUSE INFORMATION

SPOUSE'S NAME:______________________________ OCCUPATION:______________________

SPOUSE'S SOCIAL SECURITY#:____________________ SPOUSE'S DATE OF BIRTH:____________

SPOUSE'S EMPLOYER:__________________________ PHONE:_______________ EXT._______

ACCIDENT/ILLNESS INFORMATION

COMPLETE DATE OF ACCIDENT:___________________

WERE YOU INJURED: ON THE JOB ( ) AUTO ACCIDENT ( ) SCHOOL INJURY ( ) OTHER ( )

BRIEFLY DESCRIBE ACCIDENT:

____

IF NOT AN ACCIDENT, GIVE DATE OF FIRST SYMPTOM:___________________

HAVE YOU HAD THIS SAME OR SIMILAR ILLNESS? YES ( ) NO ( )

IF YES, PLEASE DESCRIBE:

____

***WE DO NOT FILE LIABILITY CLAIMS. UPON PAYMENT A RECEIPT WILL BE PROVIDED SO YOU CAN FILE FOR REIMBURSEMENT. IF YOU HAVE ANY QUESTIONS PLEASE SPEAK WITH THE FRONT DESK.**

OTHER PATIENT INFORMATION

PERSONAL /FAMILY PHYSICIAN:____________________ REFERRED BY:____________________

PARENT / GUARDIAN INFFORMATION

PLEASE COMPLETE THIS SECTION IF YOU ARE A COLLEGE STUDENT OR UNDER 21 YEARS OLD

FATHER'S NAME:_________________________________ OCCUPATION:__________________________

EMPLOYER:_____________________________________ PHONE:__________________ EXT.________

MOTHER'S NAME: ________________________________OCCUPATION:__________________________

EMPLOYER:_____________________________________ PHONE:__________________ EXT.________

PARENT'S HOME ADDRESS:____
STREET CITY STATE ZIP CODE

PARENT'S HOME PHONE:_______________________

PLEASE COMPLETE THE INSURED'S INFORMATION BELOW

INSURED = PERSON WHO CARRIES THE INSURANCE IN THEIR NAME

INSURED'S NAME:________________________________ RELATION TO PATIENT:__________________

INSURED'S DATE OF BIRTH:_________________________ INSURED'S SOCIAL SECURITY #:________________

INSURED'S EMPLOYMENT STATUS: FULL TIME ( ) PART TIME ( ) RETIRED ( )

INSURED'S EMPLOYER:____

Name of Insurance: ____

Insurance ID Number: ___________________________ Group Number:________________________

PLEASE READ AND SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Steven C. Dickhaut to release any information acquired in the course of my examination/treatment to my insurance carrier. I also authorize Dr. Dickhaut to release information to any hospital and physician I may be referred to by this office. In work- related injury cases, I authorize Dr. Dickhaut to release information to my employer.

MEDICARE / MEDICAID / SECONDARY INSURANCE ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Dr. Steven C. Dickhaut for all medical services rendered.

OFFICE POLICY / ASSIGNMENT OF BENEFITS REGARDING PRIVATE INSURANCE AND PRIVATE PAY: If my funding is private insurance or private pay, then payment is expected at time of service, unless prior arrangements have been made. I understand filing my insurance is a courtesy, and I am responsible for all costs of treatment including those of charges that exceed or are not covered by my insurance. On assigned claims, I hereby authorize payment directly to Dr. Steven D. Dickhaut for medical services rendered. I have read and understand the above statements. I agree to comply with the financial policies of this office.

SIGNATURE: (PATIENT, PARENT, OR GUARDIAN):

Signature: ____

Date:_______________

Witness Signature: ____