PLEASE PRINT

PATIENT INFORMATION DATE _____

Name _____ □ Married □ Single □ Minor □ Male □ Female
Last First MI

Address _____
Street APT# City State Zip

Contact _____ _____ _____ _____
Home Phone Work Phone Cell Phone E-Mail Address

Birth Date _____ **Age**____ **SS#** _____ **Employer** _____

FAMILY INFORMATION

Father OR Husband			Mother OR Wife		
Last	First	MI	Last	First	MI
Street	City	State Zip	Street	City	State Zip
Work Phone	Cell Phone		Work Phone	Cell Phone	
DOB	SS#		DOB	SS#	
Employer			Employer		
Insurance Name	ID#		Insurance Name	ID#	

PERSON RESPONSIBLE

Please check only one

□ Patient
□ Mother or Wife
□ Husband or Father
□ Other

EMERGENCY CONTACT

List contact person other than immediate family

Name _____
Address _____
City/State/Zip _____
Telephone _____

Whom may we thank for this referral? _____

AUTHORIZATIONS

I herby assign all medical benefits to which I am entitled (for service rendered) including Medicare and government sponsored programs, private insurance and any other health plans to **Dr. Stephen S. Rodrigues**. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Dr. Rodrigues to release all information necessary to secure the payment of said benefits. A photocopy at this assignment is to be considered as valid as the original.

Signature _____ Date _____

Please remember that insurance is a contract between you and your insurance carrier. Depending on your plan, you may be ultimately responsible for payment over and above your co-payment and your deductible of your medical bills.

Stephen S. Rodrigues, MD 5445 LaSierra Drive, Suite 102 Dallas, TX 75231
214.572.0333 214.572.0328 FAX