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PATIENT INFORMATION

Patient's Name (First, Middle, Last): ______________________________

Address: ______________________________

City: ______________ State: ______ Zip Code: __________ Email: ______________

Main Contact#: ______________ Alternate#: ______________ Work#: ______________

Date of Birth: _____/_____/______ Sex: ○ Male ○ Female SS# (optional): ______________

Marital Status : ○ Single ○ Married ○ Divorced ○ Widowed Occupation: ______________

Patient Referred By: ______________ Spouse's Name: ______________

Spouse's Date of Birth: _____/_____/______ Main Contact#: ______________ Alternate#: ______________

Emergency Contact: ______________ Relationship: ______________ Phone#: ______________

Primary Care Physician: ______________ Phone#: ______________

Referring Physician: ______________ Phone#: ______________

Other Patient Information

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: ______________(Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: ______________Please Specify)

Insurance Information

Primary Insurance: ______________ Policy/ID# ______________

Name of Policy Holder: ______________ DOB: _____/_____/_____ Group/Acct #: ______________

Employer: ______________ Employer Address: ______________

City: ______________ State: ______ Zip Code: __________ Work #: ______________

Secondary Insurance: ______________ Policy/ID#: ______________

Name of Policy Holder: ______________ DOB: _____/_____/_____ Group/Acct #: ______________

Employer: ______________ Employer Address: ______________

City: ______________ State: ______ Zip Code: __________ Work #: ______________

Complete – Only if Patient is a Minor

Father's/Guardian Name: ______________ Relationship: ______________

Mother's/Guardian Name: ______________ Relationship: ______________

Siblings: ______________ DOB: _____/_____/_____ Other Siblings: ______________ DOB: _____/_____/______

Assignment to Pay Insurance Benefits

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to MCNT, an affiliate of USMD Affiliated Services or UANT, an affiliate of USMD Affiliated Services. This assignment is for services rendered to me by MCNT, an affiliate of USMD Affiliated Services or UANT, an affiliate of USMD Affiliated Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I understand that failure to notify MCNT, an affiliate of USMD Affiliated Services or UANT, an affiliate of USMD Affiliated Services, of any changes or insurance coverage will result in the financial obligation to rest fully on myself regardless of any contract between the insurance company and MCNT, an affiliate of USMD Affiliated Services or UANT, an affiliate of USMD Affiliated Services.

Signature____ Date____________________

Patient/Guardian

Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to MCNT, an affiliate of USMD Affiliated Services or UANT, an affiliate of USMD Affiliated Services, unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needlestick (any such test shall be conducted pursuant to the MCNT, an affiliate of USMD Affiliated Services or UANT, an affiliate of USMD Affiliated Services, infectious disease protocol); or 3)if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of MCNT, an affiliate of USMD Affiliated Services or UANT, an affiliate of USMD Affiliated Services, if any of these situations occur during your treatment period.

Signature____ Date____________________

Patient/Legal Representative

____ Date____________________

Relationship to Patient

____ Date____________________

Witness