6705 Heritage Pkwy Ste 102 Rockwall, TX 75087 Phone: 972.722.2526 Fax: 972.722.2528

PATIENT

Last Name:	
First Name:	
Preferred Name:	
Middle Name:	
Previous Name:	
Sex:	
Date of Birth:	
SSN: (for billing)	
Address:	
Address (ctd):	
Zip Code:	
City:	
State:	
Home Phone Number:	
Cell Number:	
Consent to Text:	
Work Number:	
Email Address:	
Contact Preference:	
Language:	
Race:	
Ethnicity:	
Marital Status:	
Pharmacy:	
How did you hear about us: _____	

Guardian

Last Name:	
First Name:	
Phone Number:	

Emergency Contact

Name:	
Relationship:	
Home Number:	
Cell Number:	

Next of Kin

Name:	
Relationship:	
Phone:	

Employment

Employer Name:	
Employer Phone:	
Job Title:	

Insurance

Insurance Name:	
Insurance Address:	
Insurance Phone #:	
Insurance ID #:	
Insurance Group #:	
Primary on Insurance:	
Primary Date of Birth:	
Primary SS #:	
Relationship to Patient:	

ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release: I, the undersigned, authorize payment of medical benefits to GLOW, Dr. Theresa M Conyac, MD, for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize GLOW to release to my insurance company, referring physician and other consultants on my case information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

PATIENT SIGNATURE: _____ DATE: _____