DFW MDcare
inspiring better health

Please fill out this form completely.

1. **Patient Information**

Last Name_____ First Name_____ Middle _____

Sex (M/F) _____

DOB_____

Home Address_____

City_____ State_____ Zip_____

Phone (Home)_____ Email address_____

Employer Name_____

2. **Guarantor Information (who brings the minor)**

Relationship with Primary Insured (Self/Spouse/Child/Other)_____

If you did not check Self, please fill out the following info about the responsible person

Last Name_____ First Name_____ Middle MI _____

Sex (M/F) _____ Marital Status (Married/Single/Other)_____

DOB_____ Drivers License #_____ SSN_____

Home Address_____

City_____ State_____ Zip_____

Phone (Home)_____ Phone (Work)_____ Phone (Cell)_____

Email address_____

3. **Primary Insured Information**

Insurance Company Name_____ _

Phone_____

Health Plan ID_____

Member ID_____

Group Number_____

Name of the Primay Insured_____

Relationship with primary insured (circle one): Self | Spouse | Child | Other

Secondary Insurance Name: Same as Primary (Yes/No)

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Authorization to Leave Messages with Family Members or Answering Machine

From time to time it is necessary for representatives of DFWMDCare to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call DFWMDCare regarding an issue or concern. At no time will a representative of DFWMDCare discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name _____

Patient/Representative Signature _____

Consent to Photo

I hereby authorize DFWMDCare to take digital photographs of me. I understand that the photograph is only be used for my personal medical record serving a purpose of identification.

Patient/Representative Signature: _____ Date: _____