ALFRED J. RODRIGUEZ, M.D.

PATIENT INFORMATION RECORD

(**PLEASE PRINT OR WRITE LEGIBLY)**

Photo ID checked

PATIENT INFORMATION

DATE: CHART NO.:

PATIENT'S NAME (LEGAL)	MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
PATIENT'S ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO.	
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) HOW LONG?	BUSINESS PHONE		
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE	CELL PHONE	
TEXAS DRIVERS LICENSE NUMBER	E-MAIL ADDRESS (OPTIONAL)			
DRUG ALLERGIES	PEANUT ALLERGY YES NO			
SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	AGE	SOCIAL SECURITY NO	
SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) HOW LONG?	BUSINESS PHONE		
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE		
TEXAS DRIVERS LICENSE NUMBER				
NUMBER OF CHILDREN AND AGES				
FOR EMERGENCY CONTACT NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	HOME PHONE NO.		
FOR EMERGENCY CONTACT NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	HOME PHONE NO.		

INSURANCE INFORMATION - INSURANCE CARD MUST BE PRESENTED AT APPOINTMENT

INSURANCE CO NAME (PRIMARY)	POLICYHOLDER'S CO NAME	POLICY NUMBER/GROUP NUMBER
MAIL INSURANCE CLAIMS TO (STREET, CITY, STATE, ZIP CODE)		
INSURANCE CO. NAME (SECONDARY)	POLICYHOLDER'S CO NAME	POLICY NUMBER/GROUP NUMBER
MAIL INSURANCE CLAIMS TO (STREET, CITY, STATE, ZIP CODE)		
REFERRED BY		

In order to Control our costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees.

My payment will be made for services rendered by: (please check one)

CASH CHECK MASTER CARD VISA (OR)

Previous arrangements made and approved by business office.

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plan to ALFRED J. RODRIGUEZ, M.D.. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement 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 payment. **I understand that I may be billed for any missed appointment not canceled without 24 hours notice. I also understand that my insurance will not pay for missed appointments.**

Signed: _____ Date: _____