GARY GOFF, MD
INTERNAL MEDICINE

THR Presbyterian Hospital Dallas
8440 Walnut Hill Lane
Professional Building 4, Suite #420
Dallas, TX 75231
214.879.9966

Patient Name	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.					
First Name			Middle Initial			
Last Name			I prefer to be called			
Date of Birth			SSN			
Marital Status	☐ S ☐ M ☐ W ☐ D		Sex	☐ M ☐ F	Age	
Street Address						
City		State		Zip		
Phone	Home:		Work		Cell	
Please circle the phone number you prefer we call for contact or messages						
E-mail Address:						
Emergency Contact:						
Relationship to Patient			Phone			
Please list other members of your immediate family who will be joining the Concierge Service:						
Name/DOB		Name/DOB				
Name/DOB		Name/DOB				
Name/DOB		Name/DOB				

EMPLOYER & INSURANCE			
This will help us when ordering labs or diagnostic test for you.			
Employer or Retired from			
Insurance (please present card to be copied)			
Subscriber Name (if other than patient)		DOB	
Relationship to Patient (if other than self)			

BILLING			
You may pay your $125 registration fee with a debit or credit card, which is due at the time of sign up			
AutoPay with a debit or credit card is available and is required for monthly payments			
☐ AutoPay with Debit or Credit Card	Please select your Plan	☐ Gold Plan	☐ Platinum Plan
☐ Visa ☐ MasterCard ☐ Discover ☐ American Express			
Annual Payment of	☐ Gold Plan ($1,068/yr)	☐ Platinum Plan ($2,988/yr)	
Quarterly Payment of	☐ Gold Plan ($267/qtr)	☐ Platinum Plan ($747/qtr)	
Monthly Payment of	☐ Gold Plan ($89/mo)	☐ Platinum Plan ($249/mo)	
Name as it appears on card			
Card Number		CVV	
Expiration Date		Billing Zip Code	
I authorize Gary Goff MD to apply charges to the card listed above.			
Card information will not be stored in your medical records.			

Patrient Signature (or Responsible Party/Guarantor Signature) Date

By signing this form, you accept that a full physical evaluation needs to be done in office to discuss all details.