Patient Information Form

Patient Name: (Last)_____(First)_____(MI) _____

Patient Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____ Cellular: _____

Birthdate: _____ Age: _____ E-mail: _____

Are you currently covered under a Medicare/Medicaid policy? Yes No

Employment Information:

Patient Employer: _____ Occupation: _____

City: _____ State: _____ Zip: _____

Work phone No: _____Ext. _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

How did you hear about us? _____

In our continuing effort to respect your privacy and maintain the confidentiality of your care, please indicate in the space below how you want to be contacted. (Phone / home / cell / work / e-mail please explain).

AUTHORIZATION TO RELEASE INFORMATION ABOUT PATIENT'S CONDITION/TREATMENT

Dear Patient,
In accordance with the Medical Privacy Act of Texas, Our staff is unable to release any information pertaining to your condition, treatment and/or care without your consent. If you authorize us to release and/or obtain information regarding your care to someone other than yourself, please complete the following authorization.

I hereby authorize Physician's and/or staff of The M.D.'s Weight & Wellness Center, to release information pertaining to my condition and/or care to only those family members, physicians and/or others involved with my care as listed below:

Name	**Relationship**	**Telephone Number**
Name	**Relationship**	**Telephone Number**

_____ _____

Patient's Signature or Person with Authority to Consent for Patient **Date**