LARRY WEIDER, M.D.
211 W. COLORADO
PAVILION II, SUITE 929
DALLAS, TX 75208

PATIENT INFORMATION REGISTRATION FORM

PATIENT: ____

AGE: __________ DOB: __________ SOCIAL SECURITY NO.______________________________

DRIVER'S LICENSE NO__________________ SEX M F HOME PHONE__________________

ADDRESS ______________________ CITY ______________STATE ____ ZIP ________

EMAIL ADDRESS______________________________

EMPLOYER ______________________ OCCUPATION ______________________

BUS ADDRESS ______________________ CITY ______________STATE______ZIP________

WORK PHONE ______________________ MARITAL STATUS M S D W

SPOUSE'S NAME ______________________________ SOC. SEC. ________________

DOB __________________ SPOUSE'S EMPLOYER ______________________________

SPOUSE'S WORK PHONE __________________ EMPLOYER'S ADDRESS ________________

CITY __________________ STATE __________ ZIP ____________

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

NAME ______________________________ RELATION TO PATIENT ________________

ADDRESS & PHONE IF DIFFERENT THAN ABOVE ______________________________

____

EMERGENCY CONTACT
OTHER THAN SPOUSE______________________________ PHONE ______________

HOW WERE YOU REFERRED TO OUR PRACTICE? ______________________________

REASON FOR VISIT TODAY ______________________________________

DUE TO INJURY Y N DATE OF INJURY ______________ JOB RELATED Y N AUTO RELATED Y N

NAME OF INSURANCE COMPANY ______________________________ ID # ______________

GROUP # __________________ NAME OF POLICY HOLDER ______________________________

POLICY HOLDER'S ADDRESS __________________ CITY __________ STATE ______ ZIP ________

POLICY HOLDER'S HOME PHONE NO. ______________ POLICY HOLDER'S DOB______________

POLICY HOLDER'S EMPLOYER ______________________ EMPLOYER'S PHONE NO. ______________

EMPLOYER'S ADDRESS ___________________________________ CITY _______________ STATE _________ ZIP ______________

SECONDARY COVERAGE Y N

IF YES, NAME OF INSURANCE COMPANY ___________________________________ ID NO. _______________________________

GROUP NO. ___________________________ NAME OF POLICY HOLDER ____________________________________

POLICY HOLDER'S ADDRESS ______________________________ CITY ______________ STATE ___________ ZIP ___________

POLICY HOLDER'S HOME PHONE NO. ____

POLICY HOLDER'S EMPLOYER ____________________________________ EMPLOYER'S PHONE NO. ________________________

EMPLOYER'S ADDRESS ____________________________________ CITY _____________ STATE ___________ ZIP ___________

HOW WILL YOU BE PAYING FOR TODAY'S VISIT? PLEASE CIRCLE ONE OF THE FOLLOWING METHODS OF PAYMENT:
CASH WORKMAN'S COMP CHECK INSURANCE MEDICARE MEDICAID

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED WITH NO EXCEPTION. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE TO LAURENCE WEIDER, M.D. ON MY BEHALF FOR ANY SERVICES RENDERED TO ME. SOME SERVICES RENDERED BY LAURENCE WEIDER, M.D. MAY NOT BE COVERED BY MY INSURANCE. I UNDERSTAND IT IS MY RESPONSIBILITY FOR PAYMENT OF SUCH SERVICES REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE. I AUTHORIZE DR. WEIDER TO FURNISH MY INSURANCE COMPANY(S) ANY RECORDS REQUESTED BY THEM.

____ DATE _________________________
SIGNATURE OF PATIENT OR GUARDIAN