Texas FamiliCare Medical Group
Robert A. Strzinek, Ph.D., D.O.

PATIENT INFORMATION

Date: _____-_____-_____

Name: _____ Birth date: _____-_____-_____ Age _____ Sex: M/F

Address: _____ City:_____ State:_____ Zip: _____

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

Social Security#_____-_____-_____ Driver's License #_____ State _____

Marital Status: (circle one) Single, Married, Divorced, or Widowed

Employer: _____Address:_____

Patient's Occupation: _____

Name of Spouse: _____ Spouse's SS#: ____-____-____ Birth date: ____-____- ____

Spouse's Employer:_____Address_____

Spouse's Occupation: _____

Spouse's Work Phone#: _____ Spouse's Cell Phone#: _____

Emergency Contact: _____ Relationship: _____ Phone#:_____

Reason for Office Visit: _____

If changing Physician: Name, Address and Phone #_____

SIGNATURE REQUIRED ON LINE BELOW BEFORE YOU CAN BE TREATED.
SIGNATURE FOR AUTHORIZATION FOR TREATMENT: _____ Date: _____

Primary Insurance: _____ Insured's Name: _____

Group #: _____Member #:_____ Birth date: _____-_____-_____

Secondary Insurance: _____ Insured's Name: _____

Group #: _____ Member#: _____ Birth date: _____-_____-_____

I understand if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes, that I am responsible for all physician charges and non-covered medical services.

Patient's Signature: _____ Date: _____