Brazos Valley Endocrinology, PA, and Crumpler Diabetes & Education, PLLC
PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

SSN: _____ GENDER: _____ ETHNICITY: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: HOME: _____ CELL: _____ WORK: _____

E-MAIL: _____

FAX: HOME: _____ WORK: _____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____

Please complete this section regarding your insurance coverage and present your card at front desk. This information is necessary for prior authorizations, prescription medication formularies, referrals, hospitalizations, imaging studies, and laboratories. No claims will be filed for your clinic visits or other services provided at Brazos Valley Endocrinology, PA, and/or Crumpler Diabetes & Education, PLLC.

PRIMARY INSURANCE: _____ PHONE: _____

INSURED NAME: _____ RELATIONSHIP: _____

POLICY/ID NUMBER: _____ GROUP: _____

SECONDARY INSURANCE: _____ PHONE: _____

INSURED NAME: _____ RELATIONSHIP: _____

POLICY/ID NUMBER: _____ GROUP: _____

PERSON FINANCIALLY RESPONSIBLE:

NAME: _____ DOB: _____

SSN: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: HOME: _____ WORK: _____

RELATIONSHIP TO PATIENT: _____

CONSENT TO TREAT:

I voluntarily consent to medical treatment and procedures that may be performed on me during this visit. This includes, but is not limited to, medical therapy or surgical care, x-rays, ultrasounds, tests, medications, injections, laboratory tests, or other services, which may be ordered by the physician participating in my care.

This authorization must be signed by patient or responsible Party/Guarantor in the case of a minor or when patient is physically or mentally incompetent.

X_____ Date: _____

Patient, Responsible Party, or Guarantor Signature