ABDEL K. FUSTOK, M.D.

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Date: _____ Home Ph# _____Cell Ph#_____

PATIENT INFORMATION

Last name:_____First Name:_____MI:_____ SS/PT ID# _____
Address:_____Email:_____
City:_____ST:_____ZIP:_____ D/O/B:_____ Age:_____ Sex: M____ F____
Marital Status: Married:___ Widowed:___Single: ___ Minor:___ Separated:___ Divorced:____
Patient Employer/School:_____ Employer/School Ph#:_____
Employer/School Address:_____
Whom may we thank for referring you? _____
In case of emergency who should be notified?_____
Emergency contact ph# _____

PRIMARY INSURANCE

Person Responsible for Account (last name, first name, mi):_____
Relation to Patient:_____D/O/B:_____ SS#:_____Ph#:_____
Address if different from Patient:_____City:_____ TX:_____ ZIP:_____
Person Responsible Employed by:_____Ocupation:_____
Business Address:_____ Bus Ph#:_____
Insurance Company:_____
Contract#:_____Group#:_____Subscriber#:_____
Names of other Dependents Covered Under this plan:_____

ADDITIONAL INSURANCE

Is Patient Covered by Additional Insurance? YES ___ NO___ Subscriber Name:_____D/O/B:_____
Relation to Patient:_____ SS#:_____ PH#:_____
Address if different from Patients:_____City:_____ ST:_____ ZIP:_____
Subscriber Employed by:_____Ph#_____
Insurance Company:_____
Contract#:_____Group#:_____Subscriber#:_____
Names of other dependents covered under this plan:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____(name of insurance company(s)) and assigned directly to Dr._____all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**