

PREMIER MEDICLINIC

CLINIC LOCATIONS:

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Thank you for choosing our Practice. Who may we thank for referring you?

PATIENT INFORMATION

Name _____ Birthdate _____

Female Male Single Married Divorced Widowed SS # _____

Age _____ Driver's License _____ Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip Code _____

Do you have Medical Insurance Yes No If NO, how do you intend to pay? Check Cash Credit Card

GUARANTOR INFORMATION

Name of Spouse _____ Birthdate _____ SS# _____

Employer's Name _____ Work Phone _____

Address _____ City _____ State _____ Zip Code _____

INSURANCE INFORMATION

Name of Insured _____ Birthdate _____

Name of Employer _____ Work Phone _____

Employer's Address _____ City _____ State _____ Zip Code _____

Insurance Company _____ Policy # _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip Code _____

Do you have any additional Insurance? Yes No If Yes, Complete the Following:

Name of Insured _____ Birthdate _____

Name of Employer _____ Work Phone _____

Employer's Address _____ City _____ State _____ Zip Code _____

Insurance Company _____ Policy # _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip Code _____

Medicare Number _____ Medicaid Number _____

In case of emergency, we must have a phone number other than "your" home or work. We need a neighbor's, relative's or friend's number:

Name _____ Relationship _____ Phone _____

ASSIGNMENT OF INSURANCE BENEFITS CONSENT TO RELATIONSHIP

I Authorized payment of insurance benefits otherwise payable to me directly to the doctor. In the event my insurance does not cover payment for visits and / or procedures performed by Shahid, M.D., I acknowledge full responsibility for payment of services rendered. I also consent to treatment by the health care providers of this medical practice. I also hereby authorize the release of any information concerning my health care, advice, and given an opportunity to object to disclosures of my protected health information.

Patient's Signature _____ Date _____