

# Patient Information

DOCTOR OF RECORD  
Andrew E Park, MD

TSC

PATIENT NAME (First Name, Middle Initial, Last Name) <b>Robert Plock</b>	PATIENT ID (Office Use Only) <b>42157</b>	Mobile <b>(214) 799-7775</b>	Work <b>(214) 275-4195</b>	THIRD PHONE (MOBILE)
ADDRESS <b>6827 Latta Parkway</b>	DATE OF BIRTH <b>07/26/1968</b>	SOCIAL SECURITY NUMBER <b>456-53-3292</b>	SEX (M or F) <b>[X]M [ ]F</b>	MARITAL STATUS <b>[X]Married [ ]Single [ ]Other</b>
CITY, STATE, ZIP <b>Dallas, TX 75227</b>	AGE <b>45 yrs</b>	EMERGENCY CONTACT PERSON <b>Abner, Clarence</b>	RELATIONSHIP TO PATIENT <b>Acquaintance</b>	CONTACT PHONE <b>(214) 799-7774</b>
EMPLOYER <b>Spencer A/C Heating</b>	OCCUPATION <b>HVAC Tech</b>	PATIENT E-MAIL ADDRESS <b>robplock@gmail.com</b>		
REFERRING DOCTOR NAME & ADDRESS <b>Christensen M.D., William T 3434 Swiss Ave, Suite 206 Dallas, TX 75204 (214) 828-5775 (214) 828-5777</b>				
PRIMARY CARE DOCTOR NAME & ADDRESS				
RACE		ETHNICITY		

## Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name) <b>Robert Plock</b>	Mobile <b>(214) 799-7775</b>	Work <b>(214) 275-4195</b>	THIRD PHONE (MOBILE)
ADDRESS <b>6827 Latta Parkway</b>	DATE OF BIRTH <b>07/26/1968</b>	SOCIAL SECURITY NUMBER <b>456-53-3292</b>	
CITY, STATE, ZIP <b>Dallas, TX 75227</b>	SEX (M or F) <b>[X]M [ ]F</b>	PATIENT'S RELATION TO RES <b>SELF</b>	
EMPLOYER <b>Spencer A/C Heating</b>	OCCUPATION <b>HVAC Tech</b>	RESP PARTY ID (Office Use Only) <b>44032</b>	

## Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)  
☐ Patient (same as above) ☐ Responsible Party (same as above) ☐ Other (complete below)

INSURANCE COMPANY NAME	COPY AMOUNT <b>100% Patient</b>	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP			
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH			
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED	
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER	INSURED'S OCCUPATION	

## Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)  
☐ Patient (same as above) ☐ Responsible Party (same as above) ☐ Other (complete below)

INSURANCE COMPANY NAME	INSURED'S NAME (First Name, Middle Initial, Last Name)			
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP			
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH			
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED	
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER	INSURED'S OCCUPATION	

## Authorization and Acknowledgement

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

Signature of Patient / Parent / Guardian

Printed Name

Date

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian / Insured

Printed Name

Date