



Birthdate: \_\_\_\_\_ Marital Status:(circle one):

Address: \_\_\_\_\_ City: \_\_\_\_\_  
(street or P.O.Box)

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employment Status:

Occupation: \_\_\_\_\_

Employers name: \_\_\_\_\_

Employers address: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_(ext)\_\_\_\_\_ Other phone (cell, etc): \_\_\_\_\_

### **Primary Insurance**

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Group name or number: \_\_\_\_\_ Insured ID #: \_\_\_\_\_

Policy holder (circle one) : Patient      Other

Name of policy holder (if other than patient): \_\_\_\_\_

Relationship of the patient to the policy holder: \_\_\_\_\_

SS# (policy holder): \_\_\_\_\_ Birthdate (policy holder) \_\_\_\_\_

Name and address of employer of policy holder: \_\_\_\_\_

**(Please have a copy of your insurance card for the receptionist at your visit)**

### **Secondary Insurance**

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Group name or number: \_\_\_\_\_ Insured ID #: \_\_\_\_\_

Policy holder (circle one) : Patient      Other

Name of policy holder (if other than patient): \_\_\_\_\_

Relationship of the patient to the policy holder: \_\_\_\_\_

SS# (policy holder): \_\_\_\_\_ Birthdate (policy holder) \_\_\_\_\_

Name and address of employer of policy holder: \_\_\_\_\_

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**(Please have a copy of this insurance card for the receptionist at your visit)**

### **Referral Information**

Who referred you to Dr. Johns? \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Please Read**

#### **Notice of Privacy Practices**

Texas Health Care, P.L.L.C. (TCH) and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in every TCH office. A copy is available from every office and is [available for download](#) at DAJMD.com. We would like your acknowledgement that you have been advised of this notice and it has been made available to you.

#### **Assignment of Benefits**

I hereby assign, transfer, and set over to THC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric, and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company, or any balance due after payments by my Insurance Company.

#### **Appointment of Authorized Representative**

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

**All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.**

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(signature)

# Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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Signature of Patient or Personal Representative

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Date

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Name of Patient or Personal Representative

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Description of Personal Representative's Authority

Use this button to **erase all entries** and start over.

Use this button to save a copy for your records and/or print and bring to your appointment.

Use this button to submit your information to Texas Health Care.