Northeast Tarrant Internal Med Assoc
469 Westpark Way
Euless, Texas 76040

phone (817) 283-2888
fax (817) 283-1181

PATIENT INFORMATION

NAME (Last, First, Middle)	SS#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	EMAIL ADDRESS			
CITY, STATE ZIP	HOME PHONE		DAYTIME NUMBER	
PRIMARY CARE PHYSICIAN	CONTACT NAME		CONTACT HOME PHONE	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (If Different Than Above)

NAME (LAST, FIRST MIDDLE	SS#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)			
CITY, STATE ZIP	CITY, STATE ZIP			
HOME PHONE	HOME PHONE			
RELATIONSHIP TO PATIENT				

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMOUNT	
CITY, STATE ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSRUANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMOUNT	
CITY, STATE ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

I authorize the release of any medical information required to process claims. I also authorize payment of medical benefits to Northeast Tarrant Internal Medicine Associates if they choose to accept assisgnment. If is customary to pay for services when renedered unless other arrangements have been made. I understand that I am financially responsible for all charges. I also authorize my physician based on his/her discresion to asscess my chart for utilization management review. The above information is correct as the date below.

SIGNATURE OF PATIENT/GUARDIAN DATE