PEDRO M. ARGUELLO, M.D., F.A.C.P.
PATIENT INFORMATION

Patient Name: ____ Date: ____/____/___
Last First Middle

Home Address ______________________________City_______________,Texas Zip Code ______________

SS# __________________________________ Male Female Birthday _____/_____/_____ Age _______

Home (______) ____________________ Cell (______) ____________________ Work (______)______________

Marital Status: Minor Single Married Divorced Separated Widowed

Patient's Employer: ____ Work (_____)_____________________

Address______________________________ City _______________ State___________ Zip Code________

Spouse Name: ___________________________ Phone #: (_____) ___________________________

E-mail address:____

Pharmacy name & phone#:____

Person to contact in case of emergency other then spouse: _____________________________________

Name of Referring or Primary Physician:____

RESPONSIBLE PARTY

If insurance is not in patient's name please fill out the next line

Name of insured ____________________________________ Relationship to patient____________________

SS # ___________________________ ف Male ف Female Date of birth: _____/_____/______

Address ___________________________ City__________________ State__________ Zip Code___________

INSURANCE INFORMATION

Primary Insurance___________________________ID#______________________ Group # _____________

Secondary Insurance _________________________ID #______________________ Group # ____________

I give permission to Pedro M. Arguello, M.D. to discuss my treatment, treatment options or financial information with the following person(s):____

INSURED'S OR AUTHORIZED PERSON SIGNATURE: I understand and agreed that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. (I AGREE TO BE RESPONSIBLE FOR PAYMENT OF SERVICES) I authorize release of any medical or other information necessary to my insurance company for payment of medical benefits to the undersigned physician Pedro M. Arguello, M.D.
I am responsible for notifying Pedro M. Arguello, M.D. office, if any changes in my information or coverage. I have received and sign a copy of "The Health Insurance Portability & Accountability Act of 1996 (HIPPA)

____ _______/_______/________
Signature of Patient or Guardian **Date**