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 (______) ________________________

E-mail address:____

Marital Status: Minor Single Married Divorced Separated Widowed

Patient's Employer: _________________________________ Work (_____)__________________

Address______________________________ City ______________ State________ Zip Code______

Spouse Name: __________________________ Phone #: (_____) ___________________________

Pharmacy name & phone#:____

Person to contact in case of emergency other than spouse: ______________________________

Name of Referring or Primary Physician:____

<u>RESPONSIBLE PARTY</u>

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

Name of insured ________________________________ Relationship to patient________________

SS # __________________________ ﻗﻒ Male ﻗﻒ Female Date of birth: _____/______/______

Address _________________________ City_______________ State__________ Zip Code___________

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**