Christopher S. Abel, MD

PATIENT INFORMATION

8350 N. Central Expressway
Suite M-1025
Dallas, TX 75026
(214) 368-6341
(214) 368-5803 (fax)

PATIENT NAME:______________________, ______________________, ______________________
(LAST) (FIRST) (MIDDLE)

ADDRESS:______________________ APT#:______ CITY:______________________ STATE:_________ZIP:_______________

HOME PHONE #:_(______)____________________ DATE OF BIRTH: ________ / ________ / ____________ SEX: Male / Female (*circle* one)

REFERRED BY:____

SIBLING INFORMATION:

NAME:______________________DATE OF BIRTH:________/_________/____________ Male / Female *(circle one)*

NAME:______________________DATE OF BIRTH:________/_________/____________ Male / Female *(circle one)*

MOTHER'S INFORMATION:

NAME:______________________, ______________________, ______________________
(LAST) (FIRST) (MIDDLE)

ADDRESS:______________________ APT#:______CITY:______________________STATE:__________ZIP:_______________

HOME PHONE #:_(______)____________________ WORK PHONE #:_(______)____________________MOBILE PHONE #:_(______)____________________

DATE OF BIRTH:____________________ EMPLOYER:______________________OCCUPATION:______________________

MARITAL STATUS: Single / Married / Divorced / Widowed / Other *(circle one)* SOCIAL SECURITY #:______________________

FATHER'S INFORMATION:

NAME:______________________, ______________________, ______________________
(LAST) (FIRST) (MIDDLE)

ADDRESS:______________________ APT#:______CITY:______________________STATE:__________ZIP:_______________

HOME PHONE #:_(______)____________________ WORK PHONE #:_(______)____________________MOBILE PHONE #:_(______)____________________

DATE OF BIRTH:____________________ EMPLOYER:______________________OCCUPATION:______________________

MARITAL STATUS: Single / Married / Divorced / Widowed / Other *(circle one)* SOCIAL SECURITY #:______________________

INSURANCE INFORMATION:

PRIMARY INSURANCE CO:______________________INSURED NAME:______________________

ADDRESS:______________________CITY:______________________ STATE:________ZIP CODE:__________________

ELIGIBILITY PHONE #:_(______)______________________ CLAIMS PHONE#:_(______)______________________INSURED DATE OF BIRTH:_____/_____/_________

PATIENT RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / LEGAL GUARDIAN / OTHER *(circle one)*

POLICY NUMBER: ______________________GROUP NAME:______________________ GROUP NUMBER:______________________

SECONDARY INSURANCE CO:______________________INSURED NAME:______________________

ADDRESS:______________________CITY:______________________ STATE:________ZIP CODE:__________________

ELIGIBILITY PHONE #:_(______)______________________ CLAIMS PHONE#:_(______)______________________INSURED DATE OF BIRTH:_____/_____/_________

PATIENT RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / LEGAL GUARDIAN / OTHER *(circle one)*

POLICY NUMBER: ______________________GROUP NAME:______________________ GROUP NUMBER:______________________

AUTHORIZATION AND ASSIGNMENT: I HEREBY AUTHORIZE CHRISTOPHER S. ABEL, M.D., P.A., TO RELEASE TO MY INSURANCE CARRIER AND OR THEIR AGENTS ANY INFORMATION NECESSARY TO DETERMINE BENEFITS PAYABLE FOR RELATED SERVICES CONCERNING MY ILLNESS AND TREATMENTS AND I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO CHRISTOPHER S. ABEL, M.D., P.A. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL SERVICES WHETHER COVERED BY INSURANCE OR NOT. I ALSO AUTHORIZE MY PHYSICIAN, BASED ON HIS/HER DISCRETION TO ACCESS MY CHILD'S CHART FOR UTILIZATION MANAGEMENT.

PARENT/LEGAL GUARDIAN SIGNATURE:____ **DATE:**____________________________