Christopher S. Abel, MD
Susan Bacsik, DO

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:_____