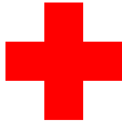

CALVARY MEDICAL CLINIC

"WHERE YOUR HEALING BEGINS"

❍108 WILLIAM BARNETT AVE
❍117 S. WILLIAM BARNETT AVE SUITE A
❍117 S. WILLIAM BARNETT AVE SUITE B
CLEVELAND, TX 77327

❍309 HWY 59 S. LOOP
LIVINGSTON, TX 77351

Date: _______/_______/_______

Patient's Name:____DOB:_______/_______/_______ Age:_____ Sex: ❍Male ❍Female SS#: ________-________-________ DL #: ____________________ ST: _________ ❍Single ❍Married ❍Separated ❍Divorced ❍Widowed Home Phone #: (________) ________-___________ Cell Phone #:(________) ________-___________ Patient Or Parent / Guardian Email Address:____

Address:____

City:____State:_______________________ Zip:_____________ Patient Employer:____

Occupation:____ Work Phone #: (________) ________-___________

Employer's Address: ____

City:____State:_______________________ Zip:_____________ Spouse's Name: ____ Spouse's DOB: _______/_______/_______ Spouse's Employer: ____ Occupation: ____________________ Employer's Address: ____

City:____State:_______________________ Zip:_____________ Referred By: ❍Phone Book ❍Newspaper ❍Hospital ❍Another Physician ❍Friend/Relative ❍Other:____

<u>WITH WHOM MAY WE SHARE INFORMATION ABOUT YOUR ACCOUNT WITH</u>? Name: ____ Relationship: ____Phone #: (________) ________-_________ <u>WITH WHOM MAY WE SHARE INFORMATION ABOUT YOUR MEDICAL RECORDS WITH</u>?

Name: ____ Relationship: ____Phone #: (________) ________-_________ ✱✱<u>IN CASE OF AN EMERGENCY WHO MAY WE NOTIFY?</u>✱✱ Name: ____ Relationship:______________________ Hm Ph #:(________) ________-_________ Cell Ph #:(________) ________- _________ Wk Ph #:(________) ________-________ ✱✱<u>WHO IS RESPONSIBLE FOR PAYMENT</u>✱✱

Name: ____ Relationship:______________________ Hm Ph #: (________) ________-_________ Cell Ph #: (________) ________- _________ Wk Ph #: (________) ________-_________ Address: ____________________________________City:____________________ST:___________Zip:___________

Insurance Company: ____ Phone: (________) ________-_________ Cardholder Name:____ Relationship: ____________________________________DOB: _______/_______/_______SS#: ________-________-________

Group # Or Plan Name:_____________________________ Subscriber Or ID #:_____________________________

✱<u>Payment is expected at the time services are rendered unless previous arrangements have been made. As a courtesy our office will file your insurance claims for the physician's fees in the event of hospitalization</u>.✱ I also authorize Calvary Medical Clinic to release any information necessary in the course of my treatment required by the insurance company covering these procedures and I permit a copy of this authorization to be used in the place of the original. I understand that I am responsible for all amounts not covered by insurance. I have received a notice of this organization's privacy practices.

Patient or Parent/Guardian Signature: ____

Parent/Guardian Name*(printed)*:____