Calvary Medical Clinic

"Where Your Healing Begins"

ADULT INFORMATION FORM

Date: _____/_____/_____

Patient's Name:_____**DOB:**_____/_____/_____ **Age:**_____

Sex: ❍**Male** ❍**Female** **SS#:** _____-_____-_____ **DL #:** _____ **ST:** _____

❍**Single** ❍**Married** ❍**Separated** ❍**Divorced** ❍**Widowed** **Home Phone #:** (_____) _____-_____

Cell Phone #:(_____) _____-_____ **Alternate 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:_____

WITH WHOM MAY WE SHARE INFORMATION ABOUT YOUR ACCOUNT WITH?

Name: _____

Relationship: _____**Phone #:** (_____) _____-_____

WITH WHOM MAY WE SHARE INFORMATION ABOUT YOUR MEDICAL RECORDS WITH?

Name: _____

Relationship: _____**Phone #:** (_____) _____-_____

✶✶**IN CASE OF AN EMERGENCY WHO MAY WE NOTIFY?**✶✶**Name:** _____

Relationship:_____ **Hm Ph #:**(_____) _____-_____ **Cell Ph #:**(_____) _____ _____

Wk Ph #:(_____) _____-_____ **Alternate Phone #** (_____) _____-_____

✶✶**WHO IS RESPONSIBLE FOR PAYMENT**✶✶ **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 #:**_____

For continuity of care, I give consent for Calvary Medical Clinic to obtain my prescription history. YES NO

✶**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.**✶ **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)*:_____

Cleveland Clinics
108 S. William Barnett Ave
Cleveland TX 77327
281-592-9775
Fax: 281-432-0548

Livingston Clinic
309 Hwy. 59 S. Loop
Livingston, TX 77351
936-327-1055
Fax: 936-329-8800

Humble Clinic
8484 Will Clayton Pkwy
Humble, TX 77338
832-995-5200
Fax: 281-995-5201