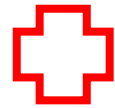


# Calvary Medical Clinic



*"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