TERRY A. CLYBURN M.D. P.A.
5420 WEST LOOP SOUTH, SUITE 2400
BELLAIRE, TX 77401
713-357-4752

PATIENT INFORMATION
DATE______________

LAST NAME____________________FIRST NAME__________________(PLEASE USE LEGAL NAME)

DATE OF BIRTH________________________SEX MALE FEMALE

SOCIAL SECURITY NUMBER_______-___-_______

MAILING ADDRESS– STREET__________________________CITY__________STATE_______ZIP_________

HOME PHONE_______________________WORK__________________CELL_________________

DRIVER'S LICENSE NUMBER__________________ISSUING STATE___________.

OCCUPATION_____________________________EMPLOYER______________________________________.

HOW WERE YOU REFERRED TO US?____.

WHO IS YOUR PRIMARY CARE DOCTOR?____.

DO YOU HAVE A CARDIOLOGIST? NO YES, AND NAME?____.

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR BILL? YOU SOMEONE ELSE IF SOMEONE ELSE, PLEASE STATE THE NAME,

ADDRESS AND PHONE-____.

NAME OF INSURANCE CARRIER?____.

WHO IS THE PRIMARY SUBSCRIBER?____.

SOCIAL SECURITY NUMBER OF SUBSCRIBER?___________-______-__________.

GROUP NUMBER_______________________. POLICY NUMBER?__________________ COPAY?________.

WHAT IS YOUR RELATIONSHIP TO THE SUBSCRIBER?____.

IF THERE IS A SECONDARY INSURANCE, WHAT IS THE CARRIER?_______________________________.

CONTACT IN CASE OF EMERGENCY

NAME____. PHONE__________________________.

ADDRESS_______________________________________. RELATIONSHIP?___________________.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician and understand that I am financially responsible for any balance. I also authorize Dr. Clyburn or insurance company to release my information required to process my claims.

Signature____Date____________________.