

DALLAS BACK ICU

10534 Garland Road
Dallas, TX 75218
Phone: 214-321-8887
Fax: 214-324-8085

Conrad A. Speece, D.O.
Medical Director

PATIENT INFORMATION

NAME: _____ BIRTHDATE: _____

HOME ADDRESS: _____ PHONE: _____

EMPLOYER: _____ WORK PHONE: _____ SOCIAL SECURITY #: _____

SEX: MALE FEMALE MARITAL STATUS: S WID DIV M

AN EMERGENCY CONTACT, OUTSIDE YOUR HOUSEHOLD: RELATIONSHIP: _____

NAME: _____ PHONE: _____

SPOUSE'S NAME: _____ BIRTHDATE: _____

EMPLOYER: _____ WORK PHONE: _____ SOC SEC #: _____

RESPONSIBLE PARTY: (if other than patient) SOC SEC #: _____

NAME: _____ SEX: M F BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____ EMPLOYER: _____

PRIMARY INSURANCE COVERAGE

DO YOU HAVE INSURANCE? YES NO

PRIMARY INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

COVERAGE EFFECTIVE DATE: _____

POLICYHOLDER NAME: _____ POLICYHOLDER SS# _____

POLICYHOLDER DOB: _____ RELATION TO PATIENT: _____

POLICY NUMBER: _____

GROUP NUMBER: _____

SUPPLEMENTAL/SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY NAME: _____ POLICYHOLDER SS#: _____

INSURANCE CO. ADDRESS: _____ POLICYHOLDER DOB: _____

POLICYHOLDER NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICY #: _____ POLICYHOLDER EMPLOYER: _____

AUTHORIZATION FOR TREATMENT: Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic procedures and medical treatment by my physician, his assistants, or his designees including consulting physicians, employees, and students in educational programs affiliated with Conrad A. Speece, D.O., as is necessary in the judgment of my physician. I consent to testing for HIV (AIDS) and or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

RELEASE OF INFORMATION: I hereby authorize Conrad A Speece, D.O. to release diagnostic and procedural information for the completion of insurance claim forms. I hereby authorize the release of clinical information to third party payors and/or their reviewing contractors to comply with preadmissions review and continued stay requirements. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued health care.

ASSIGNMENT OF BENEFITS: Authorization is hereby granted for the direct payment to Conrad A. Speece, D.O. for all benefits payable to me. I understand I am financially responsible for all changes regardless of insurance coverage.

Patient Signature

Patient's Representative

Date

Relationship to Patient