

Patient Information							
Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home	How did you hear of us?			
Address 2			Work				
			Cell				
			Email				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact			Attorney Name & Address			Phone	
			Pharmacy			Pharmacy Phone	

Physician	Family Physician(PCP)	Referring Physician
Franklin M. Douglis		

Medical Insurance	Name & Address	Type	Policyholder	Relation	Policy ID	Group ID

Guarantor (Person to be billed, if different than patient)							
1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #	
Address			Home	Work	Email		
City	State	Zip Code	Employer Name & Address			Occupation	
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #	
Address			Home	Work	Email		
City	State	Zip Code	Employer Name & Address			Occupation	

Approved Contacts							
1 Last Name	First Name	Middle	Gender	Birthdate	Social Security #		Relation
Address		City	State	Zip Code	Home	Cell	Work
2 Last Name	First Name	Middle	Gender	Birthdate	Social Security #		Relation
Address		City	State	Zip Code	Home	Cell	Work

Patient's or Authorized Person's Signature	
<p>I the undersigned give my authorization for treatment, and assign directly to Franklin M. Douglis MD PA, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. Dr. Douglis may have a financial interest in Woodlands Imaging. I hereby authorize the doctor to release all information necessary to secure the payment for my benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service. If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.</p>	
Signature	Signature Date
X	
Franklin M. Douglis MD PA 3000 West Davis, Phone: 936-539-9322 Conroe, TX 77304 Email	

Please attach all pertinent insurance ID cards for photocopying.

