

Patient Name: _____ **Social Security #** _____
(Last) (First) (MI) (Maiden Name)

Address: _____
(Street) (Apt #) (City & State) (Zip)

Date of Birth: _____ **Age:** _____ **Gender:** [] Male [] Female

Phone Numbers: Home _____ **Work** _____ **Cell** _____

Marital Status: Single Married Widowed Divorced **Texas DL #** _____

Employer: _____ **Occupation:** _____

Spouse, Parent, or Guardian Information

Name: _____

Name: _____

Relationship to Patient: _____

Relationship to Patient: _____

Social Security #: _____

Social Security #: _____

Drivers' License #: _____

Drivers' License #: _____

Address: _____

Address: _____

Home #: _____ **Work #:** _____

Home #: _____ **Work #:** _____

Employer: _____

Employer: _____

Insurance Information

Primary Insurance Co: _____

Secondary Insurance Co: _____

Name of Policyholder: _____

Name of Policyholder: _____

Insured's Date of Birth: _____

Insured's Date of Birth: _____

Authorization to Release Medical Information

I hereby consent and authorize Michael J. Polski, M.D. and his affiliates or their agents to release any medical information to

Emergency Contact Information

Name of Person to Notify In Case of Emergency: _____
(If a minor, other than parents)

Telephone #: _____

Relationship: _____

CONSENT TO TREAT: I hereby give my permission to to Dr. Polski and Staff, as he/she or they may designate, to perform and administer all treatments and diagnosis which in their judgment may be considered necessary or advisable for the patient.

RELEASE OF INFORMATION: I hereby authorize Dr. Polski and Staff to release information contained in the patient's medical records to the insurance companies, or independent contracts thereof, for the purpose of processing my insurance claims.

FINANCIAL AGREEMENT: The Undersigned hereby agrees that in consideration for services rendered, payment of the accounts is guarantee in accordance to the regular rate and terms of Dr. Michael J. Polski. The Undersigned clearly understands that payment obligation is the responsibility of the patient or parent/guardian.

ASSIGNMENT OF BENEFITS: I hereby assign to Dr. Polski and Agents associated with the care and treatment of the patient any interest and benefits provided under my insurance policy or policies. I also understand that any balance not covered by insurance is due and payable by myself.

Signature: _____ **Date:** _____