Texas Rheumatology

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Patient Information

Date_____

Number Preference (Circle One): Home/Cell /Work

Home Phone_____Cell Phone_____Work Phone_____

Patient Name_____ SSN#_____
Last Name First Name Middle Initial

Address_____ E-mail_____

City_____ State_____ Zip_____

Sex_____ Age_____ Birthdate_____ __Married __Divorced __Separated __Widowed __Single __Partnered for ___years

Family and Friends

Please list your family or friends with whom we may share your information.

_____ _____ _____

Physicians / Other Providers

Please list your physicians or other providers with whom we may share your information.

_____ _____ _____

Emergency Contact

Contact:_____Phone_____Relationship:_____

Patient Consent Regarding the Disclosure of Information

I have been given the opportunity to read the Notice of Privacy Practices and have had my questions answered by this office.

_____ _____
Patient Name (PRINT) Date Patient Signature Date

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