



DIAGNOSTIC PARTNERS OF NORTH TEXAS, P.A

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Murphy Medical Clinic, 517 West FM 544, Ste 100, Murphy TX 75094
Ph # 972-578-7700 Fax # 972-578-7705

REGISTRATION

PATIENT INFORMATION

Name _____ Last Name _____ First Name _____ DOB _____

Soc. Sec # _____ Address _____

City _____ STATE _____ Zip _____

Home phone _____ Cell phone _____

Sex: M F Single Married Widowed Separated Divorced

Occupation _____ Employer _____

Work Address _____ Work Phone _____ May we call you at work? Y/ N

How did you hear about us? _____ Reason for today's visit _____

INSURANCE INFORMATION

Medicare # _____ Medicareid # _____

Ins CompanyName _____ Policy # _____ Group # _____

Please select applicable option: Insured Self

Responsible Party Name _____ Gender _____ DOB _____

SS# _____ Relationship Self Spouse Child Other

Address (if different from patient) _____

Responsible Party's Occupation _____ Employer _____

Employer's Address _____ Business Phone _____

Additional Insurance? Yes/ No

Insurance Company _____ Policy # _____ Group# _____

Responsible Party _____ Gender M F DOB _____

SS# _____ Relationship: Self Spouse Child Other

Address (if different from patient) _____

Responsible Party's Occupation _____ Employer _____

PHARMACY INFORMATION

Pharmacy Name _____ Ph # _____ Address _____

Mail-In-Pharmacy _____

ASSIGNMENT AND RELEASE

I request that payment of authorized insurance benefits be made on my behalf to *Vijay Sharma, MD* for any services provided to me. I, on my behalf as well as on my dependent's behalf, authorize to release of a ny medical information to the insurance company needed to determine benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original until revoked in writing. **I understand that I am financially responsible for all charges whether or not covered by said insurance.**

Patient's Signature _____

Date _____

Guardian Signature _____

Relationship to the Patient _____