Diagnostic Clinic of Houston
1200 Binz, Suite 800
Houston, TX. 77004
713-797-9191

MR# _____ Date_____

Patient Information

Patient Name (Last)_____ (First)_____ (MI)_____

Address_____ Apt,_____

City _____ State _____ Zip_____ Country_____

Daytime Phone_____ Alternate Phone_____ Work Phone_____

Date of Birth_____ SSN_____ Marital Status_____

Emergency Contact_____ Relationship_____ Phone_____

E-Mail _____

Primary Language:_____ Race:_____

Ethnicity (Hispanic or Latino): Yes / No Religion:_____

Insurance

(This Information is required for proper insurance filling)

Primary Insurance_____ 0 PPO 0 HMO 0 POS Insurance Phone #_____

Subscriber Name_____ Date of Birth_____

Relationship to Insured_____ Policy #_____ Group #_____

Secondary Insurance_____ 0 PPO 0 HMO 0 POS Insurance Phone #_____

Subscriber Name_____ Date of Birth_____

Relationship to Insured_____ Policy #_____ Group #_____

Please provide receptionist with copy of your ID and Insurance cards

Assignment of Benefits and Release of Information Authorization

I understand that I am responsible for my bill. I authorize Diagnostic Clinic of Houston to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to Diagnostic Clinic of Houston. I authorize release of information necessary to collect any payments to all my insurance companies. I authorize the use of this signature for all insurance submissions. I understand that I am responsible for notifying the office of any recertification or referrals needed for my insurance. I certify that I have received, red, and understand all documents given to me in regards to HIPPA act as a patient.

Signature of Patient or Guardian_____