3535 Travis St, Ste 170, Dallas, TX 75204

Last_____First_____Middle_____

Address_____City_____St_____

Zip_____Home Phone_____Cell Phone_____

Work Phone_____D.O.B____/____/____Age_____Sex: □ M □ F

Email address:_____

Marital Status: □ Single □ Married □ Widowed □ Other SSN_____

Occupation_____Employer_____

Emergency Contact_____Phone_____

Relationship of emergency contact to patient_____

New Patients Only: Name of doctor or referring party_____

INSURANCE INFORMATION

Primary Insurance Carrier_____

Secondary Insurance Carrier_____

Responsible Party (if patient is a minor)_____

ALL PATIENTS: PLEASE READ & SIGN THE FOLLOWING

To allow us to file for your medical insurance benefits and/or accept Medicare assignment, please sign the following release:

I request that medical insurance benefits be paid directly to InfinityVision for services rendered. I authorize the release of medical information to my insurance carriers for determination of benefits.

*****IF YOU BELONG TO AN HMO OF ANY TYPE AND DO NOT HAVE A CURRENT REFERRAL, OR IF YOU ARE UNABLE TO PROVIDE PROOF OF INSURANCE AT TIME OF SERVICE, YOU WILL BE RESPONSIBLE FOR TODAY'S PAYMENT IN FULL.*****

SIGNED_____DATE_____