JOHN G. PAPAILA, MDPA

Patient Information

LAST NAME	FIRST	MI	Preferred or Nickname:
Patient Email Address:	DOB:	SSN:	Gender ☐ Male ☐ Female

RACE (select one): ☐American Indian/Eskimo ☐Asian/Pacific Islander ☐Black/African American ☐White ☐Other

****AND****

ETHNICITY (select one): ☐Hispanic or Latino ☐Not Hispanic or Latino

Healthcare Providers are required by law to report the above information to the State of Texas. Individual identifying information will not be associated with the information reported. *The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving access to adequate health care.*

Home Address:

_____

STREET (PO BOX) CITY STATE ZIP

Telephone	Preferred Contact Phone
CELL ( ) _____-_____ HOME: ( ) ____-_____ WORK:( )_____-_____	☐CELL ☐HOME ☐WORK

Spouse's Name (L-F-MI):	Parent (L-F-MI):

Spouse or Parent Telephone	Preferred Contact Phone
CELL ( ) _____-_____ HOME: ( ) ____-_____ WORK:( )_____-_____	☐CELL ☐HOME ☐WORK

Primary Insurance Company: _____	Secondary Ins Co:_____
Group Number: _____	Group Number: _____
Policy No.: _____	Policy No.: _____

Primary Insured Information (if different from patient):
Name: **Birthdate**: **SSN**:

Emergency contact that is different from spouse, parent, or guardian:	Emergency Contact Cell Phone:	Emergency Contact Work Phone:

Due to HIPAA regulations, your personal health information can not, in general, be released by this office/surgery center to anyone other than health care providers and related entities directly involved in your health care. Exceptions to this regulation require your specific consent. Complete the following information should you elect to designate an individual or individuals to whom your health information may be released:

Name (First/Last)	Relationship	DOB	Telephone Number

You may revoke this authorization at any time by notifying this office in writing that you wish to do so.

REGULAR DOCTOR:_____ OFFICE TELEPHONE: _____

REFERRING DOCTOR:_____ OFFICE TELEPHONE: _____

PHARMACY:_____

Office Use- Enter Received Date: