



**PATIENT INFORMATION (PLEASE PRINT)**

PATIENT NAME: \_\_\_\_\_  
(LAST) (FIRST) (MI)

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(STREET/PO BOX/APT #)

\_\_\_\_\_ CITY STATE ZIP

PRIMARY PHONE: \_\_\_\_\_ SECONDARY PHONE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_

MARITAL STATUS: MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED \_\_\_\_\_

RACE: \_\_\_\_\_ IS IT OK TO CONTACT YOU AT WORK: \_\_\_\_\_

PATIENT EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
(SKIP IF MINOR)

EMPLOYER ADDRESS: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PRIMARY PHONE: \_\_\_\_\_ SECONDARY PHONE: \_\_\_\_\_

**FAMILY INFORMATION**

SPOUSE: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CHILDREN: \_\_\_\_\_ DOB: \_\_\_\_\_ (IF MORE SPACE IS NEEDED,  
\_\_\_\_\_ DOB: \_\_\_\_\_ PLEASE USE BACK OF THIS SHEET)

I authorize the release of any medical information necessary to process insurance claims. I also authorize assignment of insurance benefits to T. Michael Helton, MD in the event my insurance is filed as a courtesy. I understand I am fully responsible for payment in full for services rendered by T. Michael Helton, MD, I understand that I will also incur the cost of said collections, which include reasonable attorney fees and court costs. I further authorize the release of any pertinent medical records to any physician and/or facility to which I may be referred. I give my consent for medical treatment of the patient names above to T. Michael Helton, MD. I agree to allow Dr. Helton to review my external medication history.

I hereby acknowledge that I was given the opportunity to read a copy of the Notice of Privacy Practices of T. Michael Helton, MD.

SIGNATURE: X \_\_\_\_\_ DATE: \_\_\_\_\_

IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST SIGN AUTHORIZING CONSENT