Hong Xiao, M.D.

4100 Fairway Drive Ste.320
Carrollton, Tx 75010
Phone:(972)236-7608 **Fax:**(972)236-7606

PATIENT INFORMATION:

Last Name: _____First Name:_____MI:_____

Mailing Address:_____Apt/Suite:_____

City:_____State:_____Zip code:_____

DOB:_____ Male( ) Female( ) Social Security #:_____

Home Number:_____Work:_____Mobile:_____

Email:_____ Single( ) Married( ) Other:_____

Employer:_____Address:_____

Phone:_____Email:_____

Emergency Contact: _____Phone:_____

Emergency Contacts Relationship To Patient:_____

If you would like to give authorization to someone to call in for you to book, cancel, or reschedule your appointments, request prescriptions, ask information about your account on file; you must list their first & last name, and their relationship to you.
Name:_____Relationship To Patient:_____Phone:_____

Responsible Party's Name:_____DOB:_____

Phone:_____Address:_____

Pharmacy:_____Address:_____

We reserve the right to perform urine drug tests or any similar test to determine appropriate use of controlled substances. You have the right to decline the test, however some of your medications may not be able to be prescribed.

CURRENT MEDICATIONS:

Prescribed:	Over The Counter:	Supplements/Vitamins:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: _____

Hong Xiao, M.D.
Board Certified Family Physician

Insurance Authorization And Assignment of Insurance Benefits

I hereby authorize Fairway Family Medicine to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided by Fairway Family Medicine. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked in writing by myself.

Consent for Treatment and Understanding of Financial Responsibility

I agree to general medical treatment and consent to the review and use of my medical records by Fairway Family Medicine. All professional services rendered are charged to me, the patient. I am aware that the patient is responsible for all fees, including remainder of deductible, regardless of insurance coverage. It is customary to pay for services when rendered, unless the arrangements have been made in advance.

Acknowledgment of Notice of Privacy Practice

I hereby Acknowledge that I have been presented with a copy of Fairway Family Medicine NOtice of Privacy Practice and their Office Protocol handout, and understand my responsibility as a patient of Fairway Family Medicine.

Patient Signature:_____Date:_____

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