Primary & Diagnostic Medical Centers of Texas
Mario A. Martinez MD

www.mariomd.net

(View website for contact info)

Patient Information

(Print) Contact Info:

First Name:_____**Middle:**_____**Last:**_____
Address:_____**City:**_____**State:**_____**Zip:**_____
D.OB:_____**Age:**____**Gender:**_____**SSN#:**_____
Home#:_____**Cell#:**_____**Email:**_____
Employer:_____**Work#:**_____
Spouse Name:_____**D.O.B:**_____**Cell#:**_____
Emergency Contact:_____**Relationship:**_____**Phone#**_____

Permission to leave voice/text message to the number's listed above? Yes or No (circle)

Are you the insurance policy holder? If the answer is no then please provide the insurance policy holders information in the section below. If answered (yes) please skip

Policy Holders Name:_____ **D.O.B:**_____
Address:_____**State:**_____**Zip:**_____
Relationship:_____**Home#:**_____**Cell#:**_____

If the policy holders address listed above, is different from the address that is on file with the insurance company please provide that address.

Address:_____**State:**_____**Zip:**_____

1. **Consent to release information: I hereby consent for doctors and offices to furnish information to my insurance company concerning my illness. I also consent for doctors and offices yo release information to other physicians involved in my medical treatment and ongoing care. Initial here:**_____

2. **Consent to obtain information: I hereby consent for any and other physicians, medical facility's, insurance company's or medical service providers to release information regarding my medical treatment and ongoing care to Mario A. Martinez,MD Initial here:**_____

3. **Consent to release information: I hereby consent for doctors and offices to furnish information to the person of my choice concerning my medical information. Name of person authorized to your medical information:**_____ **Patient Signature: X**_____**Date:**_____