**Flower Mound Family Physicians**

**James R. Long, M.D.** **Mandy Micheaux, PA-C** **Alexander Vanderzant, PA-C**

Patient Information

| | |
|---|---|
| First Name | Employer |
| Last Name | Address |
| Middle | City |
| Address | State, Zip |
| City | |
| State, Zip | |
| Home Phone | |
| Work Phone | |
| Cell Phone | |
| (Please Circle) Male Female | |
| Birth Date | |

Marital Status (Please Circle) Single Married Legally Separated Divorced Widowed

In order to be able to send appointment reminders and to set up a internet portal for patient /office communication please supply your personal E-mail address

Ethnicity (Please Circle) Non- Hispanic Hispanic

Race (Please Circle) African or African American; Asian or Asian American; Caucasian or European American; Native American or Native Alaskan; Native Hawaiian or Other Pacific Islander; Other Race _____

Insured Information

| | |
|---|---|
| First Name | Employer |
| Last Name | Address |
| Middle | City |
| Address | State, Zip |
| City | |
| State, Zip | |
| Home Phone | |
| Work Phone | |
| Cell Phone | |
| (Please Circle) Male Female | |
| Birth Date | |

Marital Status (Please Circle) Single Married Legally Separated Divorced Widowed

Relationship to patient (Please Circle) Spouse Mother Father Guardian Other_

Emergency Contact

| | | | |
|---|---|---|---|
| Name | | Relationship | |
| Preferred Phone # | | Alternate Phone # | |

How did you hear about us? _____

Patient Agreement

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to the practice named on the top of this form. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. It is my understanding that Flower Mound Family Physicians may choose to terminate my patient status if above guidelines are not followed. I understand that as part of my health care Flower Mound Family Physicians originates and maintains paper and or electronic health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future treatment and that these records will only be used for treatment and payment.

I wish to allow the following persons access to my medical information: _____.
This person/ persons may find out test results, medications and/or prescriptions and relay this information to me and/or pick up test results, prescriptions and/or samples for me. They may speak to this doctor's office for billing, treatment, appointments, etc. I understand that anyone not listed above cannot get any information from this facility pertaining to my treatment or care.

I wish to allow my test results/medical information to be faxed to the following personal fax number: ____-_____-_____.
I understand that if I do not supply a fax number that Flower Mound Family Physicians will not fax anything without a signed request. I also understand that shot records and return to work/school notes cannot be faxed to school or work fax numbers.

I fully understand and accept the terms of this consent.

_____ _____

Patient or Authorized Representative's Signature Date