:

MEDPEDS MEDICAL CLINIC, PA
2111 FORT WORTH HIGHWAY
WEATHERFORD, TX 76086
PATIENT UPDATE FORM

Dr. Nusrat Khan MD, MBA, CQM   Dr. Maliha Abbas DO, MS   Cory Kern PA-C   Marcie Guardiola FNP-C

My preferred pharmacy:	Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)**
			Single / Mar / Div / Sep / Wid

What would you like us to call you?	**Social Security no.**:	**Birth date**:	**Age:**	**Sex:**	
Email:	- -	/ /		❑ M	❑ F

Street address:	**My Main Phone is (please circle one)**			Cell phone no:
	Cell	Home	Work	( )

City:	State:	ZIP Code	Home phone no.:
			( )

Ethnicity: please indicate	**Race**: please check one	Work phone no.:
❑ Hispanic/Latino ❑ Non-Hispanic	❑ American Indian ❑ Asian ❑ Black ❑ White ❑ Other	( )

We can now remind you of appointments in several ways please choose your preference

❑ Cell phone		❑ Home phone
❑ Voice message	❑ text message	❑ permission to leave on machine

❑ Email reminders only to @

CONSENT FOR TREATMENT AND PAYMENT

- My signature below indicates the authorize and consent to the performance and all treatments and medical services deemed advisable by the physicians and staff of MedPeds Medical Clinic, PA I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations
- I understand I am directly responsible for the charges incurred
- MedPeds Medical Clinic will – as a courtesy – file charges to the insurance company I provide them
- I consent for my prescription history to be obtained at any time for the purposes of my medical treatment
- I consent that my personal health information may be shared and obtained from health care providers for the purposes of furthering my healthcare

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MedPeds Medical Clinic, PA 2111 Fort Worth Highway Weatherford, TX 76086 or insurance company to release any information required to process my claims.

Patient/Guardian signature

Printed Name: *Date*