John M. Moore, MD

17300 PRESTON RD, STE 160
DALLAS, TX 75252
972-867-9135

PATIENT INFORMATION

Patient Name:____
First MI Last

Address:____

City:_______________________ State:__________ Zip:__________

SS#:______/______/______ Date of Birth:__________ Male / Female

Home Phone:__________ Work:__________ Cell:__________

Email: __________ Marital Status:__________ Student status: Non/FT/PT

Patient Employer:__________ Address:_______________________
Street City/ State/ Zip

Emergency Contact:__________ Phone:__________ Relation to Patient:__________

Referring Doctor:__________Office Number:__________

Pharmacy Name/Location:__________ Phone:__________

INSURANCE INFORMATION

(This is the order in which it will be filed to your insurance company)

Primary Insurance Name:____

Subscriber Name:__________Date of Birth:__________Relation to Patient:__________

Policy Number:__________Group:__________

Employer:__________Phone:__________SS#:_____/_____/_____

Secondary Insurance Name:____

Subscriber Name:__________Date of Birth:__________Relation to Patient:__________

Policy Number:__________Group:__________

Employer:__________Phone:__________SS#:_____/_____/_____

GUARANTOR INFORMATION

(Complete if different than above information)

Name:__________Date of Birth:__________Phone Number:__________

As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility. Payment is expected at the time of service unless arrangements have been made with the office manager.

Patient's Authorization and Assignment of Benefits:

I authorize the release of any medical information necessary to process this claim and I authorize payment of surgical and medical benefits directly to Dr. John M. Moore. I understand that regardless of insurance benefits, if any, I am financially responsible for the fees for services rendered. I am also responsible for obtaining referrals (if needed), certification, or second opinion's which may be required under my insurance policy. I have completed this form the best to my knowledge.

Signature____Date:__________

***Medicare Patients Only ***

Please read carefully: I understand that Medicare may not pay for all services rendered.

Signature____Date:__________