Dumas Family Practice, LLC 120 Beard Ave, Dumas TX 79029

Date: _____

Please give information as it appears on your insurance card

Patient Information Male ___ Female ___ Child ___

Name: _____ _____ _____ _____

Last First MI Jr./Sr./II etc

Preferred Name: _____

Street Address: _____ Mailing Address: _____

City, State, Zip: _____

Phone: (_____)_____ Home ___ Cell ___ Work ____

Alternate Phone: (_____)_____ Home ___ Cell ___ Work ____

Date of Birth (mm/dd/yyyy) _____/_____/_____ Social Security # _____

Driver's License #/State _____ Employer _____

Emergency Contact _____ _____ _____

Name Phone relationship

Allergies _____

Guarantor Information Same as Patient ____

Relationship to patient: Parent ____ Husband ____ Wife ____ Other (specify) _____

Name: _____ _____ _____ _____

Last First MI Jr./Sr./II etc

Preferred Name: _____

Street Address: _____ Mailing Address: _____

City, State, Zip: _____

Phone: (_____)_____ Home ___ Cell ___ Work ____

Alternate Phone: (_____)_____ Home ___ Cell ___ Work ____

Date of Birth (mm/dd/yyyy) _____/_____/_____ Social Security # _____

Driver's License #/State _____ Employer _____

Insurance Information

Employee Group ___ Medicare___ Medicare Advantage ___ Medicaid___ Chips ___ Other ___

Policy holder's relationship to patient: Self ___ Spouse ___ Parent ___ Other ___

Policy Holder Information: Same as Patient ___ Guarantor ___

Name: _____ _____ _____ _____

Last First MI Jr./Sr./II etc

Street Address: _____ Mailing Address: _____

City, State, Zip: _____

Date of Birth (mm/dd/yyyy) _____/_____/_____ Social Security # _____

Employer _____ Group Name/Number _____

Policy Number _____

Medicare Number _____ Medicaid number _____

Do you have more than one insurance Y/N

Guarantor Signature_____ Date _____

Consent/Acknowledgment

Name_____ Date _____

I give permission to the medical personnel of Dumas Family Practice, LLC to perform assessments/examinations and render other medical services to the patient identified above. I understand the assessment may be performed by a Nurse Practitioner or Physician Assistant supervised by Dr. Chris L. Bunch. Should I wish to be seen by a physician, I will need to notify the reception and/or nursing staff of this decision.

If the patient is a minor, a parent or guardian must sign the information form and consent/acknowledgment form prior to the minor being seen by the medical staff of Dumas Family Practice, LLC for any type of medical services. The only exception is for those medical services which a minor may legally seek without parental consent. If the patient is a minor, the parent or guardian consents to this and future dates of service by signing below.

I understand the insurance information which I provide is considered a method of payment and not a substitute for payment. I understand I am fully responsible for any and all charges regardless of insurance or third party involvement. By signing below, I am giving permission to Dumas Family Practice, LLC to file the insurance forms and collect payment for medical services performed, I am assigning medical benefits to which I am entitled for the services I am receiving to Dumas Family Practice, LLC, Chris L. Bunch, MD. This assignment will remain in effect until revoked by myself in writing. A photocopy of this assignment is to be considered as valid as the original. I understand the insurance claims and statements are provided by Dumas Family Practice, LLC 120 Beard Ave Dumas, TX 79092.

I understand my insurance company may request copies of my personal health information prior to paying for services rendered. I authorize the staff of Dumas Family Practice, LLC to release any information necessary to secure payment for services I received.

Patient's Signature_____

Guarantor's Signature _____
if different from Patient
Relationship to Patient _____