Walter D. Gracia, M.D., P.A.
1204 5th Avenue
Fort Worth, TX 76104

Today's Date: _____

Have you been our patient before: Yes or No

Social Security Number _____

Patient Name	Marital Status: Circle One M / S / W / D/ Sep	DOB:	Sex:	Age:
Home Address:	City, State:	Zip:	Home Number:	
Cell Number:	E-mail Address:			
Patient's Employer	Employer's Number:	Employer Contact Person		
Employer's Address:	City, State:	Zip:	Occupation:	
Notify in Case of Emergency:	Relationship:	Home Number:	Cell Number:	
Insurance Carrier:	Policy Number: _____ Group Number:			
2nd Ins. Carrier (if applicable)	Policy No:		Group No.	
3rd Ins. Carrier (if applicable)	Policy No:		Group No.	
If Workman's Comp: _____ Claim No:		Date of Injury: _____ If any, Was Auto Involved:		
Referred By				
Reason for Visit:				
Any Drug Allergies:				

All professional services rendered are charged to the patient, necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

I hereby authorize Walter D. Gracia, MD to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered me or dependents. I understand that I am responsible for any amounts not covered by insurance. I authorize intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment below.

Patient Signature: _____ Date: _____