**LINDA I. PARKER, M.D., P. A.**
*311 N. Allen Drive*
*Allen, Texas 75013*
*(972) 727-8000*

***PLEASE COMPLETE ALL INFORMATION***

## PATIENT'S MEDICAL INFORMATION
## PLEASE PRINT

BIRTH DATE _____/_____/_____ (mo. / day / yr.) TODAY'S DATE _____

* Patient Name: _____ (Last / First / Middle)

Phone No. _____ Age _____ Sex _____ Marital Status _____ No. of Children _____

Address _____ (Street No. / Street Name / Apt. No.) Social Security No. _____

_____ (City / State / Zip)

IS THIS A WORK RELATED ACCIDENT? _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S PHONE NO. _____ Cell Phone NO. _____

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**POLICY HOLDER and / or**
**RESPONSIBLE PARTY (TO PAY BILL)** - ☐ CHECK IF SAME AS PATIENT Social Security No. _____

NAME _____ (Last / First / Middle) Birthdate _____

Relationship _____ Address _____

EMPLOYER _____ (Employer's Name / Occupation / How Long?)

EMPLOYER'S ADDRESS _____

EMPLOYER'S PHONE _____ REFERRED BY _____

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**IN CASE OF EMERGENCY NOTIFY: (Local Please)** _____ (Name / Phone No.)

ADDRESS _____ CITY _____ STATE _____

ZIP _____ WORK PHONE NO. _____

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**INSURANCE INFORMATION:** Carrier _____ Group No. _____ ID.No. _____

MEDICARE NO. _____ MEDICAID NO. _____

IF PATIENT IS A MINOR, NAME AND SIGNATURE OF RESPONSIBLE PARTY: _____ (Name)

_____ (Signature)

LIST KNOWN ALLERGIES OR REACTION TO MEDICATIONS: _____

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I AM LEGALLY RESPONSIBLE FOR PAYMENT OF MY BILLS MADE BY MYSELF OR DEPENDENTS FOR MEDICAL CARE RENDERED AT DR. LINDA I. PARKER'S CLINIC. FURTHERMORE, I AM RESPONSIBLE FOR ANY INSURANCE REIMBURSEMENT TO THE FAMILY PRACTICE CENTER OR MYSELF.

_____ PATIENT'S SIGNATURE

_____ * PATIENT'S or RESPONSIBLE PARTY'S SIGNATURE