Thomas A. Cadenhead, M.D.

2210 San Jacinto Blvd. #2
Denton, Texas 76205

PATIENT MUST BE ACCOMPANIED BY AN ADULT IF UNDER 18.

PATIENT INFORMATION: Cell Phone No.: (_____) _____

Name: _____ Age: _____ Birth Date: _____ Sex: ☐M ☐F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone No.: (_____) _____ Social Security No.: _____ Marital Status: ☐S ☐M ☐W ☐D ☐Sep

Patient's Drivers License #: _____ Work Phone No.: (_____) _____ If Student: ☐ Full Time ☐ Part Time

Patient's Employer: _____ Occupation: _____

Spouse's Name: _____ Employer: _____ Work Phone No.: (_____) _____

Emergency Contact: Name _____ Relationship: _____ Phone No.: _____

If your condition is related to an accident, please list date of the accident: _____

IF PATIENT UNDER 18 YEARS OF AGE:

Name of Person Accompanying Patient: _____ Relationship: _____

Address: _____ Home Phone No.: (_____) _____

Drivers License #: _____ Social Security No.: _____ Birth Date: _____

Employer: _____ Work Phone No.: (_____) _____

INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Patient: _____

Complete Address: _____ Home Phone No.: (_____) _____

Birth Date: _____ Social Security No.: _____ Date Employed: _____

Name of Employer: _____ Work Phone No.: (_____) _____

Insurance Company: _____ Group No.: _____ Policy ID #: _____

Co-Pay Amount: _____ Deductible Amount: _____ How much has been used this year: _____

SECONDARY INSURANCE INFORMATION: (Only if patient has Medicare as primary/secondary.)

Name of Insured: _____ Relationship to Patient: _____

Address: _____ Home Phone No.: (_____) _____

Birth Date: _____ Social Security No.: _____ Date Employed: _____

Name of Employer: _____ Work Phone No.: (_____) _____

Insurance Company: _____ Group No.: _____ Policy ID #: _____

Co-Pay Amount: _____ Deductible Amount: _____ How much has been used this year: _____

I give permission to Dr. Cadenhead and his staff to examine and treat me/my child. I hereby authorize **Thomas A. Cadenhead, M.D.,** to release to my primary care physician and/or insurance company any information acquired in the course of my examination or treatment. I hereby authorize payment be made directly to **Thomas A. Cadenhead, M.D.** I understand that I am responsible for any and all charges not paid by my insurance. A photocopy of this assignment is to be considered valid as an original.

_____ Date: _____

SIGNATURE OF PATIENT (OR PARENT IF MINOR AND STATE RELATIONSHIP)

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