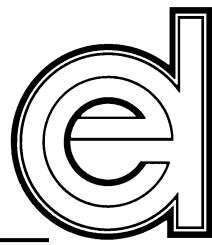


dallas diabetes and endocrine center

salomon banarer, m.d.
susan watkins, aprn,fnp-bc

Practice limited to endocrinology, diabetes and metabolism



PATIENT INFORMATION

PERSONAL INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Preferred phone _____ (cell/home)

Alternate phone _____ (cell/home)

E-mail _____

Date of birth _____ Age _____ Sex _____

Drivers License _____

Social Security Number _____

INSURANCE INFORMATION

Company _____

Insured Individual _____

Insured individual date of birth (if not patient) _____

Insured individual address (if not patient)

Policy Number _____

Group Number _____

Subscriber # _____

SECONDARY INSURANCE INFORMATION

Company _____

Insured Individual _____

Insured individual date of birth (if not patient) _____

Insured individual address (if not patient)

Policy Number _____

Group Number _____

Subscriber # _____

SPOUSE / EMERGENCY CONTACT

Name _____

Relationship to patient _____

Address _____

City _____ State _____ Zip _____

Phone _____

RESPONSIBLE PARTY (if other than patient)

Name _____

Relationship to patient _____

Address _____

City _____ State _____ Zip _____

Phone _____

Social Security Number _____

EMPLOYER INFORMATION

Employer _____

Occupation _____

Address _____

City _____ State _____ Zip _____

Phone _____

I CERTIFY THAT THE ABOVE INFORMATION IS
CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of patient or responsible party:

Printed name of patient or responsible party:

Date: _____