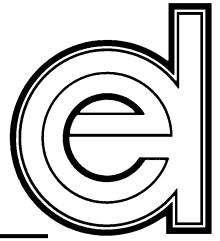


dallas diabetes and endocrine center

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: _____