LITTLE ELM MEDICAL CENTER
John G. Flores, M.D.
Jill E. Wolf, M.D.

Patient Informatioı

Patient Information (please print)

Name ____ Sex M F
Last First M

DOB ______ / ______ / ______ Email Address ______________________

SS # ______ / ______ / ______ DL # ______________________

Mailing Address ____
Street City State Zip

Primary Phone ( ) ______ - ______ Cell Home Work

Secondary Phone ( ) ______ - ______ Cell Home Work

Other Phone ( ) ______ - ______ Cell Home Work

Employer Name & Address ____

Emergency Contact ____

Telephone # ( ) ______ - ______ Relationship ______________________

Pharmacy # ( ) ______ - ______

Prescription Company ______________________ ID # ______________________

Primary Insurance	**Secondary Insurance**
Name ______________________	Name ______________________
ID # ______________________	ID # ______________________
Group # ______________________	Group # ______________________
Policy Holder ______________________	Policy Holder ______________________
Policy Holder DOB ______ / ______ / ______	Policy Holder DOB ______ / ______ / ______
Policy SS # ______ / ______ / ______	Policy SS # ______ / ______ / ______

Relationship to Patient Self Child Spouse

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other Health plar John G. Flores, M.D./Jill E. Wolf, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is t considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby autho said assignee to release all information to secure paymen

Signature ______________________________________ Date ______________________

We reserve the right to make payment adjustments for financial hardships.