GREGG T. PODLESKI, D.O.

ORTHOPEDIC SURGERY • SPORTS MEDICINE • BOARD CERTIFIED
2540 N GALLOWAY AVENUE, SUITE 302, MESQUITE, TX 75150
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PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY_____ ST_____ ZIP _____

CELL _____ HOME _____ WORK _____

SOCIAL SEC # _____ D.O.B. _____ AGE _____ GENDER → FEMALE / MALE

MARITAL STATUS → SINGLE / MARRIED / DIVORCED / WIDOWED

SPOUSE OR PARENT'S NAME _____ PHONE _____

ADDRESS (if different) _____ CITY _____ ST _____ ZIP _____

SOCIAL SEC # _____ D.O.B. _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

CELL _____ HOME _____

EMPLOYER _____ PHONE _____ FAX _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

ADDRESS _____ CITY_____ ST_____ ZIP _____

REFERRING PHYSICIAN? _____ PHONE _____

PHARMACY _____ PHONE _____

THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE DR. GREGG T. PODLESKI D.O. TO FURNISH MY INSURANCE COMPANY(S) WITH ANY INFORMATION DESIRED CONCERNING MY: HISTORY, FINDINGS, DIAGNOSIS AND TREATMENT RENDERED TO ME. I ALSO AUTHORIZE MY INSURANCE COMPANY(S) TO PAY DR. GREGG T. PODLESKI D.O. DIRECTLY. AS THE PATIENT I ACCEPT AND UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY COPAY, DEDUCTABLE OR COINSURANCE THAT MY INSURANCE COMPANY DEEMS TO BE MY PORTION. I ALSO CERTIFY THAT THE PRE-EXISTING CLAUSE, IF ANY, ON MY POLICY DOES NOT APPLY TO MY CIRCUMSTANCE IN ANY WAY AND IF FOUND OTHERWISE I AM FULLY AWARE THAT I WILL BE RESPONSIBLE FOR ALL PROCEDURE CHARGES.

SIGNATURE _____ **DATE** _____

OTHER RESPONSIBLE PARTIES SIGNATURE _____ **RELATIONSHIP TO PATIENT** _____

Revised 1/18/11