PATIENT AND INSURANCE INFORMATION

Patient's Name:__________________________________**DOB:**_______________**Age**:____________**Gender:** ☐ **M** ☐ **F**

Address:____**City:**_________________________**State:**_________**Zip:** __________

Home#:________________________**Cell #:**____________________________**Work#:**________________________________

SSN #: _____________________________________ **Driver's License #**: _______________________________________

E-mail: ____

Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** **Spouse Name:** ____________________________________

Employer:_______________________________________**Occupation**: ____

Primary Care Provider: ______________________________________ **Phone #:** __________________________________

Emergency Contact:___________________________________**Phone #**: ____

INSURANCE INFORMATION

PRIMARY:

Insurance Company:________________________**Policy #:** ___________________________ **Group #:**____________________

Subscribers Name:__________________________**Social Security #:**______________________________**DOB**: ________________

Patients Relationship to Subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**: ______________________________________

SECONDARY:

Insurance Company:________________________**Policy #:** ___________________________ **Group #:**____________________

Subscribers Name:__________________________**Social Security #:**______________________________**DOB**: ________________

Patients Relationship to Subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**: ______________________________________

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Assignment of Benefits: It is customary to pay for all services on the date rendered unless other arrangements were made before your appointment. The patient/guarantor is responsible for deductibles, co-pays, non-covered services, other services that are not considered medically necessary, as well as any other fees in accordance with insurance contracts. I hereby assign all medical benefits to which I am entitled. I hereby authorize my insurance carrier(s), including Medicare to issue payment directly to Trina Health, LLC.

I hereby acknowledge that I am fully responsible for payment as listed above.

Signed:____ **Date:** ______________________________

Complete and return to Trina Health of North Texas 1307 8th Ave. Suite 608 Ft. Worth, TX 76104

Or via email at patients@trinahealthntx.com or fax to 817-984-4678

Attach a copy of insurance card if available