FLOWER MOUND
FAMILY PHYSICIANS

**Nazia Malick, M.D.**
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| | | |
|---|---|---|
| First Name: | | Date: |
| Last Name: | MI: | DOB: |
| Address: | Apt # | Home Phone: |
| City: | State, Zip: | Cell Phone: |
| (In order to be able to send appointment reminders and to set up patient portal)<br>Email Address: | | Gender:<br>O Male O Female |
| Marital Status:<br>O Single O Married O Legally Separated O Divorced O Widowed | | Ethnicity:<br>O Hispanic O non-Hispanic |
| Race: O Caucasian or European American O African American O Asian or Asian American<br>O Native American or Native Alaskan O Native Hawaiian or Other Pacific Islander O Other _____ | | |

## PATIENT PHARMACY INFORMATION

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|---|
| Pharmacy Name: |
| Pharmacy Address: |
| Pharmacy Phone: |
| Pharmacy Fax: |

## INSURED INFORMATION

| | |
|---|---|
| Insurance Name: | |
| Name of Policy Holder:<br>DOB: | Gender:<br>O Male O Female |
| Relationship to Policy Holder: | |
| Guarantor's Address:<br>*(If different than above)* | |

EMERGENCY CONTACT

| | | |
|---|---|---|
| Name: | Relationship: | Phone Number: |
| Name: | Relationship: | Phone Number: |

## Patient Agreement

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to the practice named on the top of this form. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. It is my understanding that Flower Mound Family Physicians may choose to terminate my patient status if above guidelines are not followed. I understand that as part of my health care Flower Mound Family Physicians originates and maintains paper and or electronic health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future treatment and that these records will only be used for treatment and payment.

**I wish to allow the following persons access to any medical information (HIPAA):**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This person/persons may find out test results, medications, and/or prescriptions and relay this information to me and/or pick up test results, prescriptions, and/or samples for me. They may speak to this doctor's office for billing, treatment, appointments, etc. I understand that anyone not listed above cannot get any information from this facility pertaining to my treatment or care.

I FULLY UNDERSTAND AND ACCEPT THE TERMS OF THIS CONSENT.

_____ _____/_____/_____

Patient Name Date of Birth

_____ _____/_____/_____

Signature of patient or patient's legal representative Date

_____

Print Name and relationship to patient