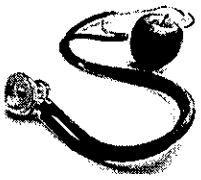

# Plano Primary Care Clinic

*Muhammad M. Farooqi, M.D. – Internal Medicine*
4101 W Spring Creek Pkwy, #300 Plano, Texas 75024
Ph: 972-398-8161 Fax: 972-398-8121

PATIENT INFORMATION **Date** _____

**Name**_____ **SSN:** _____

**Address**_____ **Home Ph:** _____

**City** _____ **State** _____ **Zip Code**_____

**Sex** ( ) M ( ) F **Age**_____ **Date of Birth**_____ ( ) **Single** ( ) **Married Patient**

**Employed by**_____ **Occupation**_____

**Business Address**_____ **Business Ph:** _____

**Whom may we thank for referring you?** _____

**In case of emergency who should be notified?** _____ **Phone:** _____

| **Primary Insurance** | **Secondary Insurance** |
|---|---|
| **Ins. Co. Name** _____ | **Ins. Co. Name** _____ |
| **Address** _____ | **Address** _____ |
| **City** _____ | **City** _____ |
| **State** _____ **Zip** _____ | **State** _____ **Zip** _____ |
| **Phone #:** _____ | **Phone #:** _____ |
| **Subscriber ID#:** _____ | **Subscriber ID#:** _____ |

**Assignment and Release**

I, the undersigned certify that I (or my dependent) have insurance with _____ and assign directly to **Plano Primary Care Clinic** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

(Responsible Party Signature) (Relationship) (Date)

I will be paying today by: ( ) Cash ( ) Check ( ) Credit Card