PATIENT IDENTIFICATION

Chart/EMR #_____ Date:_____

NAME _____
Last First Middle Initial

MAILING ADDRESS_____
Number Street City Zip

SOCIAL SECURITY# _____TX. Drivers Lic #_____

BIRTHDATE _____ RACE_____

Married _____ Single _____ Male _____ Female _____ Home Ph: _____

Employer: _____ Work ph._____

GUARANTOR, SPOUSE, PARENT _____

Social Security # _____ Birthdate _____

Address:_____
Number Street City Zip

Employer _____

Address: _____

Name of Insurance Co. _____Policy Number: _____

Name of Policyholder:_____

Medicare # _____Medicaid # _____

E-MAIL_____ Referral Method_____

STM Primary Care Clinic 901 E Esperanza Ave. McAllen, TX 78501

LONG-TERM ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

NAME: _____ Acct #: _____

I request that payment under the MEDICAL INSURANCE PROGRAM be made directly to Kallumadanda PLLC (STM Primary Care Clinic) on any unpaid bills furnished me by these physicians during the time period of _____ to _____.

This will approve the release of necessary information to the MEDICAL INSURANCE PROGRAM for the purposes of submitting a claim against my medical insurance policy.

SIGNED: _____ DATE: _____
(PATIENT)

PERSONAL HEALTH INFORMATION RELEASE

I hereby authorize STM Primary Care Clinic to release personal health information on the above named individual to the following:

Name	**Relationship**	**Telephone**
_____	_____	PH:_____
_____	_____	PH: _____
_____	_____	PH: _____

(This will include notification or change in appointments, notification of lab or special study results, messages to return call to the physician or nurse.)