Joshua L. Weiss, M.D. Associated
12201 Merit Dr., #325
Dallas, TX 75251

PATIENT INFORMATION

DATE: _____/_____/_____ REFERRING PHYSICIAN/ MIDWIFE: ____________________________

PATIENT'S NAME: ____
(FIRST) (MIDDLE) (LAST)

DOB: ______/______/______ AGE: _____ SOCIAL SECURITY #: _______-_____-_________

HOME PHONE: (_____) _____-_______ WORK :(_____) ______-_______CELL :(_____) ______-________

HOME ADDRESS: ____ APT. #: ______

CITY: ____ STATE: ________ ZIP CODE: _________

EMPLOYER: ____

SPOUSE/ PARTNER'S NAME:

____
(FIRST) (MIDDLE) (LAST)

DOB: ______/______/______ AGE: ______ SOCIAL SECURITY #: _____-_____-____________

EMPLOYER: ____

EMERGENCY CONTACT INFORMATION

NAME: ____ RELATIONSHIP: _________________

HOME PHONE: (___) ____-______ WORK PHONE :(___) ____-______CELL PHONE :(___) ____-______

Please provide the best contact phone numbers, at which we can contact you or leave a message regarding the following:

- **Lab results**
- **Appointment reminders**
- **Changes to scheduled appointments**
- **Billing information**

PRIMARY #: (_____) ______-________ HOME CELL WORK

ALTERNATE #: (_____) ______-________ HOME CELL WORK

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PATIENT INFORMATION

AUTHORIZATION TO DISCUSS PROTECTED INFORMATION

I, ______________________________________, authorize Dr. Joshua L. Weiss, M.D. to release, or discuss,
(PRINT NAME)
Any patient information related to my medical condition including: treatment plan, medications, and/or billing information, to my insurance carrier, and my referring physician, and to the following persons listed:

1) ____ 2) ____

3) ____ 4) ____

- **PLEASE BE ADVISED: Any person not listed on the above list, will NOT be given any information related to your care, including billing information. You may change, restrict, or expand this list at any time.**
- **You are not required to list any name(s) if you do not so choose.**

ADVANCE DIRECTIVE/LIVING WILL

Do you have an advance directive or living will? **Yes _____ No _____**

If no, are you interested in receiving information pertaining to one? **Yes _____ No _____**

I CERTIFY THAT ALL INFORMATION PROVIDED IS TRUE AND CORRECT, TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: ________________________________ DATE: _____/_____/_____