

**Brian C. Forsythe, D.O.**

4525 Lemmon Avenue, Suite 200

Dallas, Texas 75219-2100

Phone: (214) 526-4525 • Fax: (214) 520-6468

Name \_\_\_\_\_

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ \*Cell Phone \_\_\_\_\_

\*Email \_\_\_\_\_ \*Fax \_\_\_\_\_

\* Requires authorization. See *Confidential Communication Release* for signature.

Sex M F Marital Status Single Married Widowed Divorced

Spouse's / Partner's Name \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy \_\_\_\_\_ Location \_\_\_\_\_ Phone \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ \*Cell Phone \_\_\_\_\_

\*Email \_\_\_\_\_ \*Fax \_\_\_\_\_

\* Requires authorization. See *Confidential Communication Release* for signature.

Primary Insurance Plan \_\_\_\_\_ ID# \_\_\_\_\_ Group \_\_\_\_\_

*I authorize the release of any medical information necessary to process my claim and payment of medical benefits to Brian C. Forsythe, D.O..*

Signature of Patient / Responsible Party \_\_\_\_\_ Date \_\_\_\_\_