W. E. Furniss II, M.D.

4800 N. E. Stallings Dr, Suite 109
Nacogdoches, TX 75965
(936) 564-2421

Medicare Patient Information

First Name _____ Middle Initial ____ Last Name _____

Date of Birth _____ Social Security Number _____

Address _____

City_____ State _____ ZIP Code _____

Main Phone _____ Work/Alternate Phone _____

Cell Phone _____ E-Mail Address _____

Spouse's Name_____ Work Phone _____

Spouse's Social Security Number_____ Date of Birth _____

Nearest relative not living with you_____ Phone _____

Nearest friend not living with you_____ Phone _____

Primary Care or Referring Physician_____ Phone _____

Dentist _____ Phone _____

Whom may we contact in the case of an emergency?

_____ Phone _____

Whom may we thank for referring you to us?

_____ Phone _____

Who is responsible for this bill? _____

Did you sustain an injury at work? Y N Are you covered under an employer or union policy? Y N

Are your injuries accident related? Y N Is your spouse or other family member employed? Y N

Are you currently employed? Y N Do you have a secondary insurance policy? Y N

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professi9onal services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature Date