Date: ______________________

Dr. Paul W. John M.D.
11671 Jollyville Rd. Suite #202
Austin, TX 78759

Patient Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

SOCIAL SECURITY NUMBER:	SEX: ☐ FEMALE ☐ MALE	DATE OF BIRTH: MONTH / DAY / YEAR	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

ADDRESS:	CITY:	STATE:	ZIP CODE:

EMAIL ADDRESS:	HOME PHONE: ( ) -	CELL PHONE: ( ) -

EMPLOYER:	OCCUPATION:	EMPLOYER'S TELEPHONE: ( ) -

EMPLOYER ADDRESS:	CITY:	STATE:	ZIP CODE:

REFERRING PHYSICIAN:	TELEPHONE: ( ) -

PLEASE CHOOSE:
- ☐ AMERICAN INDIAN OR ALASKA NATIVE (I)
- ☐ ASIAN (A)
- ☐ BLACK OR AFRICAN AMERICAN (B)
- ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER (P)
- ☐ WHITE (W)
- ☐ OTHER (O)
- ☐ DECLINED (7)

PRIMARY LANGUAGE:

PREFERRED PHARMACY:	LOCATION:	TELEPHONE: ( ) -

PREFERRED CONTACT METHOD:
☐ PHONE ☐ TEXT ☐ EMAIL

Insurance Information

INSURANCE CARRIER:	CLAIMS ADDRESS:

MEMBER ID #:	GROUP #:

POLICY HOLDER NAME:	DATE OF BIRTH: MONTH / DAY / YEAR	RELATIONSHIP:

ADDRESS:	CITY:	STATE:	ZIP CODE:

HOME PHONE: ( ) -	CELL PHONE: ( ) -	WORK PHONE: ( ) -

POLICY HOLDER'S EMPLOYER:	ADDRESS:

CITY:	STATE:	ZIP CODE:	EMPLOYER'S PHONE: ( ) -

CONSENT FOR TREATMENT: I do hereby consent to necessary examination procedures and/or treatments prescribed by my physician, his/her assistants, or designees in his/her judgement.

______________________ SIGNED (Insured Person)

__________ DATE

______________________ WITNESS