

Emily A. Sheveland, D.O.
5236 W. University Dr. #3200
McKinney, TX 75071
(972) 548 -1717

All information on "Chart Cover" provided me has been reviewed and corrected for accuracy and represents up-to-date insurance and personal information.

Signature: _____ Date: ____ / ____ / ____

In order to keep our patients' expenses at a minimum, payment is expected at the time of your visit.
If this is a problem, please let the receptionist know how you plan to make payment *before* seeing the doctor.
Signing this form will give us the ability to release medical information to your insurance company and other physicians and lets us know that you are aware of our payment policy. Thank you.

PATIENT SIGNATURE

Date

PARENT (IF PATIENT IS A MINOR)

NEW PATIENT /UPDATED INFORMATION

PLEASE PRINT

NAME _____ BIRTHDATE ____ / ____ / ____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SEX: M F RACE: _____ ETHNIC GROUP : Hispanic or Latino / Not Hispanic or Latino / Decline

MARITAL STATUS: Married / Single Last 4 Digits of SSN: ____ - ____ - ____ - ____

EMPLOYER _____ WORK PHONE (____) _____ - _____

EMAIL _____ CELL PHONE (____) _____ - _____

PREFERRED CONTACT METHOD: Cell Phone or Work Phone

Pharmacy Name, Number and location _____ / _____ / _____

EMERGENCY CONTACT _____ Relationship _____
PHONE # (____) _____ - _____

BILLING INFORMATION

INSURED/SUBSCRIBER _____ RELATION TO PT. (circle one) parent / spouse / self

ADDRESS _____ DATE OF BIRTH ____ / ____ / ____

CELL PHONE (____) _____ - _____ WORK PHONE (____) _____ - _____

NAME OF INSURANCE COMPANY _____

CO-PAY \$ _____ DEDUCTIBLE AMOUNT \$ _____

SECONDARY INSURANCE? Y or N IF YES, NAME OF SECONDARY: _____