YOLANDA LAWSON, M.D., P.A.
2509 Thomas Ave
Dallas, TX. 75201

EXISTING PATIENT UPDATE INFORMATION FORM

Provider you are seeing today _____Referred by _____
Patient Name _____Date of Birth _____ SSN # _____
Address _____City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
Email _____ May we email you personal info? Y/N

Best number to call with test results _____ Is it OK to leave message? Y/N

Your employer _____Address_____
City _____Zip _____ Phone # _____

In case of emergency notify_____Relationship_____
Home # _____ Work # _____ Cell # _____

I do/do not give permission for my medical information to be shared with (list names):
_____

INSURANCE INFORMATION

PRIMARY INSURANCE
Insurance name _____ID # _____ Group # _____
Name of Insured _____ Date of Birth _____
Insured SS # _____ Relation to patient _____
Insured Employer _____ Address _____
City _____ State _____Zip _____ Phone # _____

SECONDARY INSURANCE
Insurance name _____ID # _____ Group # _____
Name of Insured _____ Date of Birth _____
Insured SS # _____ Relation to patient _____
Insured Employer _____ Address _____
City _____ State _____Zip _____ Phone # _____

IMPORTANT INFORMATION

- All patients are required to give a 24 hour notice for any appointment cancellations. There will be a $25.00 charge for all missed appointments without this notice.
- There is a charge for copying of all medical records. Please give a written request. First 20 pages $25.00 plus .50 for every page after that. This office has 30 days to fulfill your request.
- There are miscellaneous charges for additional clerical services (i.e. disability forms, physician letters, etc.). Please ask our front desk for details.

I hereby authorize the provider indicated above to furnish information to insurance carriers and I hereby irrevocably assign all benefits for payment for medical services rendered to this provider. Verification of benefits are not a guarantee of payment by the insurance company. I understand that I am responsible for all charges whether covered by insurance or not.

Patient Signature _____Date_____

Guarantor Signature _____ Date_____