Patient Demographic Information

First:	Middle:	Last:	DOB:/
Social Security Number: Marital Status:			OFFICE USE ONLY
Sex assigned at birth: M	M F Gender identity:	Pronouns:	' HT:' ' '
Street Address:			WT:
City:			B/P:/
State:	Zip:		O2:%
Home: ()			HR:
Cell: ()	-		TEMP:
Email Address:	<u></u>	Local Pharmacy:	
Emergency Contact:		Mail Pharmacy:	
Phone of Contact Person	:()		
Patient's Employer Spouse's Employer:		er:	
Street Address:		Street Address:	
State:	_Zip:	State:	Zip:
Who should we thank	for the referral?		· · · · · · · · · · · · · · · · · · ·
	Acknowledgement of	Review of Notice of Privac	cy Practices
	titled to receive a copy of the	· · · · · · · · · · · · · · · · · · ·	cal records will be used and disclosed. I
minor surgery or psychol information to any consu	logical ailment by using medi ultants or facilities referred to	ications and medical instrument	ence to diagnose and treat me for any medical is. I also authorize release of medical nsurance company or to the following listed ary.
1)	2)	3)	4)
insurance company and or routine follow-up appoin	outstanding amount not cove tments at a frequency recom	red by my insurance will be my	rstand that all charges will be filled with my responsibility. I understand that I will need uation of refill on medications. I agree to pay ges.
Signature:		Date:	
		dian if patient is minor or menta	

Mauli Dalal, M.D. (Family practice)

Raj Dalal, M.D. Internal Medicine (Professional Association)

192 Abner Jackson Parkway, Lake Jackson, TX-77566