Norman J. Torres MD • 1011 Medical Plaza Drive, Suite 130 The Woodlands, TX 77380 • Phone: 832-585-9191 • Fax: 832-369-4935

Patient Information

			TODAY'S DATE
Last Name, First Name, Middle Initial		Date of Birth	Age
Gender ☐ Male ☐ Female	Social Security Number	Marital Status	
Home Phone Number	Work Number	Cell Phone	
Address	City	State	Zip Code
Email address	Ethnicity – *Please select one* ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to Report		
Race – *Please select one* ☐ American Indian or Alaska Native ☐ Asian	☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander	☐ White ☐ More than one race ☐ Decline to report	
Emergency Contact	Emergency Contact Relationship to Patient	Emergency Contact Number	
Primary Care Physician (PCP)	PCP Address, Phone, Fax		
Name of Referring Physician (if different from PCP)	Referring Physician's Address, Phone, Fax		

Work Information

Employer Name (Company Name)		Employer Phone Number	
Work Address	City	State	Zip Code

Guarantor/Responsible Party Information **(if different from patient)**

This person is the person who is responsible for billing charges.

Last Name, First Name, Middle Initial		Date of Birth	Age:
Gender (circle one): Male Female	Social Security Number	Marital Status	
Home Phone Number	Work Number	Cell Phone	

I certify that the person listed above is responsible for billing charges. I understand that any amount not covered by insurance will be required of the person listed above.

Signature_____ Date_____

Norman J. Torres MD • 1011 Medical Plaza Drive, Suite 130 The Woodlands, TX 77380 • Phone: 832-585-9191 • Fax: 832-369-4935

NOTE TO PATIENTS:

NJTORRES NEUROSURGERY DOES NOT ACCEPT MEDICAID. PLEASE CHECK WITH THE FRONT OFFICE IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE.

I understand that NJTorres Neurosurgery does not accept Medicaid.

Signature_____ Date_____

Insurance Coverage Information

Please read carefully and fill out completely.

Primary Insurance

Insurance Carrier		
Subscriber's Name and relationship to patient	Subscriber's Date of Birth and Subscriber's Employer	
Address		
Insured ID Number	Group Number	Effective Date

Secondary Insurance **(if applicable)**

Insurance Carrier		
Subscriber's Name and relationship to patient	Subscriber's Date of Birth and Subscriber's Employer	
Address		
Insured ID Number	Group Number	Effective Date

Tertiary Insurance **(if applicable)**

Insurance Carrier		
Subscriber's Name and relationship to patient	Subscriber's Date of Birth and Subscriber's Employer	
Address		
Insured ID Number	Group Number	Effective Date

I have filled this out to the best of my knowledge. I understand that if any of my insurance information listed above changes, that I should notify the office immediately.

Signature_____ Date_____

Norman J. Torres MD • 1011 Medical Plaza Drive, Suite 130 The Woodlands, TX 77380 • Phone: 832-585-9191 • Fax: 832-369-4935

Patient Pharmacy Information

In order to ensure the timely processing of your prescriptions, please be sure to notify the office of any changes to your pharmacy information.

Primary Pharmacy

			TODAY'S DATE
Patient Name			
Pharmacy Name (e.g. Walgreens, CVS, Sams Club)			
Street Address			
City	State	Zip Code	
Pharmacy Phone:	Pharmacy Fax:		

Alternative Pharmacy (if applicable)

			TODAY'S DATE
Pharmacy Name (e.g. Walgreens, CVS, Sams Club)			
Street Address			
City	State	Zip Code	
Pharmacy Phone:	Pharmacy Fax:		

I certify that I have filled out the above information to the best of my knowledge.

Signature_____ Date_____

Norman J. Torres MD • 1011 Medical Plaza Drive, Suite 130 The Woodlands, TX 77380 • Phone: 832-585-9191 • Fax: 832-369-4935

Consent to Disclose Private Healthcare Information for Treatment, Payment, And/Or Healthcare Operations

I, _____, Social Security Number_____, date of birth_____, hereby authorize and consent for the clinic of Norman J. Torres, MD, PA, 920 Medical Plaza Drive, Suite 150, The Woodlands, TX 77380 to release any and all medical, and/or psychological reports or records, including, but not limited to, medical notes, physician narratives, office notes, operative notes, discharge summaries, doctor's orders, nurse's notes, lab reports, physical therapy notes, pathology reports, radiological and diagnostic report and any records reflecting treatment for substances abuse, mental illness, AIDS, HIV virus, alcohol abuse, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalizations, and any other personal health information regarding medical care as necessary to carry out treatment, obtain payment, and/or conduct other healthcare operations.

A copy of this authorization is agreed by the undersigned to have the same effects and force as an original. This consent to disclose private healthcare information may be revoked in writing. However, such a revocation shall not be effective on an entity that has taken action on reliance upon this consent prior to its revocations and/or if this is consent was obtained as a condition of obtaining insurance and a law provides the insurer the right to contest a claim under the policy. Any person, firm, or entity that release matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from release of those matters.

I further acknowledge that the information used or disclosed pursuant to this authorization may be subjected to redisclosure by the recipient and no longer be protected by the privacy regulations.

I further understand that I have the right to review the clinic of Norman J. Torres, MD, PA's privacy notice and to request restrictions.

Signature
_____Date_____

Printed Name_____

Signer's Relationship to Patient (if other than patient) _____

Special Restrictions:

_____

_____

_____