Dr. Kimberly Udell
3602 Matlock Road Suite 206, Arlington, TX 76015
Phone 817-468-1506
Fax 817-468-1520

PATIENT DEMOGRAPHICS

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Age: _____ Date of Birth: _____ Social Security #: _____

Preferred Pharmacy: _____ Pharmacy Phone #:_____ Zip: _____

Race: Caucasion_____African American_____Native American_____Asian_____Other_____Decline____

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____ Other_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____Work #: _____Cell Ph#: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

INSURANCE POLICY INFORMATION

Name of PRIMARY Insurance Plan: _____

Subscriber ID#: _____ Group #:_____

Patient Relationship to Subscriber: Self _____ Spouse _____ Child _____ Other _____

Policy Holder Information (if other than self)

First Name: _____ Last Name: _____Middle Initial: _____

Date of Birth: _____ Employer: _____

- **WE DO NOT ACCEPT SECONDARY INSURANCE**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicaid, Private Insurance, and any other Health Plan to:

KIMBERLY UDELL, D.O., P.A.

This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: _____ DATE: _____