R. Terry Garbacz, D.O.
1518 10th Street - Wichita Falls, TX 76301-4405
Phone: (940) 767-3376 • Fax: (940) 767-1013

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Name: _____

E-Mail: _____ Employment Status: ☐ Employed ☐ Retired ☐ Student

Employment Information

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Responsible Party Information (For Minors)

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ (City, State, Zip): _____

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Relative to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

How Were You Referred to Our Office?

☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Internet Search ☐ Other

Please print the name of your source: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to R. Terry Garbacz, D.O. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I have read and understand the posted HIPAA certification document.
I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____