

Leslie C. Hardick, D.O.  
 1325 Pennsylvania Avenue,  
 Suite 350  
 Fort Worth, TX 76104

Clinic \_\_\_\_\_  
 F.C. \_\_\_\_\_

**Patient Information**

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
 Nombre Apellido \_\_\_\_\_ Primer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Dirección / Calle / Apt \_\_\_\_\_ Ciudad \_\_\_\_\_ Estado \_\_\_\_\_ Código \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M F Age \_\_\_\_\_ Race \_\_\_\_\_  
 Teléfono \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ Sexo \_\_\_\_\_ Edad \_\_\_\_\_ Raza \_\_\_\_\_

Marital Status S M D W Sep \_\_\_\_\_ SSN \_\_\_\_\_ Driver's License No. \_\_\_\_\_  
 Estado Civil \_\_\_\_\_ Seguro Social \_\_\_\_\_ Licencia o I.D. \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Nombre de Empleo \_\_\_\_\_ Teléfono de Empleo \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Dirección de Empleo \_\_\_\_\_ Ciudad \_\_\_\_\_ Estado \_\_\_\_\_ Código \_\_\_\_\_

Emergency Contact (other than spouse) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Contacto de Emergencia \_\_\_\_\_ Relación \_\_\_\_\_ Teléfono \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Dirección \_\_\_\_\_ Ciudad \_\_\_\_\_ Estado \_\_\_\_\_ Código \_\_\_\_\_

Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Persona Responsable \_\_\_\_\_ Relación \_\_\_\_\_ Teléfono de Empleo \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Nombre de Empleo \_\_\_\_\_ Teléfono de Empleo \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Sex F M \_\_\_\_\_  
 Fecha de Nacimiento \_\_\_\_\_ Seguro \_\_\_\_\_ Sexo \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Dirección \_\_\_\_\_ Ciudad \_\_\_\_\_ Estado \_\_\_\_\_ Código \_\_\_\_\_

Name of Referring Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Primary Insurance Medicare Medicaid HMO PPO Military Other \_\_\_\_\_

Plan Code \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_

Plan/Group No. \_\_\_\_\_ Policy \_\_\_\_\_

Effective Date \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

Secondary Insurance Medicaid HMO PPO Military Other \_\_\_\_\_

Plan Code \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_

Plan/Group No. \_\_\_\_\_ Policy \_\_\_\_\_

Effective Date \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

I authorize the physician to release any information in the course of my examination or treatment and permit payment directly to the physician at his/her election any benefits due for services rendered. I recognize and accept responsibility for any balance remaining after payment of such benefits (excluding Medicaid recipients). By law physicians are required to file Medicare claims for patients. Patients are not allowed to file claims with Medicare.

Yo autorizo al médico deprender cualquier informacion en el curso de mi examinacion o tratamiento y permito pago directamente al médico cualquier beneficio por sus servicios yo reconozco y acepto responsabilidad por cualquier balance despues del pago di beneficio (exclusivo pacientes con Medicaid). Se requiere por ley que el médico mande cobrar a Medicare para los pacientes. El paciente no debe mandar cobrar a Medicare.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_