

**PLEASE FILL IN ALL APPLICABLE BLANKS.**

Jennifer Aldrich M.D. P.A.  
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214-382-5810  
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**Patient Name:** \_\_\_\_\_  
First Middle Last

**Preferred Name / Nickname:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
Street Address Apt # City State Zip

**Home Phone #:** \_\_\_\_\_ **Cell Phone #:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_

Where would you like to receive calls about your appointments, labs and x-ray results or other health information?  
( ) Home ( ) Cell Phone ( ) Work Phone

**Sex:** M F **Date of Birth:** \_\_\_\_\_ **Marital Status:** ( ) Married ( ) Divorced ( ) Widowed ( ) Single ( ) Partner

**Email:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Employment Status:** ( ) Full Time ( ) Part Time ( ) Self Employed ( ) Not Employed ( ) Retired

**Policy Holder Information (If different than above)**

**Policyholders Name:** \_\_\_\_\_ **Primary Phone #:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
Street Address Apt # City State Zip

**Sex:** M F **Date of Birth:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Employer:** \_\_\_\_\_ **Employer Phone #:** \_\_\_\_\_

**Insurance Information (Primary)**

**Name of Insurance:** \_\_\_\_\_ **Phone # for Claims:** \_\_\_\_\_

**ID #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Claims Address:** \_\_\_\_\_

**Insurance Information (Secondary)**

**Name of Insurance:** \_\_\_\_\_ **Phone # for Claims:** \_\_\_\_\_

**ID #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Claims Address:** \_\_\_\_\_

**Assignment of Benefits**

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Jennifer Aldrich M.D. Services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment 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 understand that I am responsible for any amount not covered by insurance.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_