William A. Anderson, M.D.
800 Eighth Avenue, Suite 510
Fort Worth, Texas 76104
Phone: (817) 334-0908 *Fax: (817) 334-0989*

DATE:_____

NAME:_____ DOB:_____AGE:_____

ADDRESS:_____ SS#:_____

CITY/ST/ZIP: _____ Martial Status: [ ] Married [ ] Divorced [ ] Single

_____ Sex: [ ] M [ ] F

Home Phone: _____ Cell Phone: _____

Employment: _____ Work Phone: _____

Referring Doctor:_____ Primary Doctor:_____

Responsible party information: (Please present card to receptionist)

Primary Insurance:_____

Subscriber:_____

Group #: _____ ID #: _____

Secondary Insurance:_____

Subscriber:_____

Group #: _____ ID #: _____

I approve assignment of all insurance benefits to Dr. William Anderson for services rendered. I understand that I am financially responsible for all charges not covered by my insurance company (deductible, co-insurance, co-pay, etc.). Signature of this page authorizes insurance submission of all claims.

Dr. William Anderson may use my health information and may disclose such information to the above named insurance carrier and/or their agents for the purpose of obtaining payment for services. This consent will end when my current treatment plan is completed or one year from the date of this signature.

_____ _____ _____

Signature of patient/guardian Relationship Date