TLC Medical Center
Brian Rich, D.O. & Daniel Wagner, M.D.

Clinical Intake Information
Personal Information

Patient Name:_____Today's Date:_____

Date of Birth:_____Age:_____Social Security #:_____

Gender: Male/Female Marital Status: Single/Married/Divorced/Seperated/Widowed

Address:_____City/State/Zip:_____

Employer:_____Occupation:_____

Home Phone:_____Cell Phone:_____

Work Phone:_____Email:_____

In the event of an emergency with you, whom should we contact:_____
Relationship:_____Phone #:_____

Responsible Party / Insured

Name:_____Relationship:_____

Date of Birth:_____S.S. #:_____phone:_____

Address:_____City/State/Zip:_____

Employer:_____Work Phone #:_____

Insurance Company Name:_____

I.D. #_____Group #:_____

Authorization & Release

I authorize the release of any information including diagnosis and the records of any treatment rendered to me or to my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give this office the right to seek the services of a bill collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid for services rendered.
Disclaimer: I agree to hold TLC Medical Center, Physicians and staff harmless for any and all accidents occurring at 7326 Staples, Corpus Christi, TX 78413. Clients/Parents/Guardians are responsible for all damage to property.

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Signature of Patient/Parent/Guardian Print Name Today's Date