

**North Plano Internal Medicine
Dr. Steven C. Strength
Board Certified - Internal Medicine**

Date: _____

Name: _____
(Last, First, M.I.)

Address: _____ City/State: _____

Zip: _____

Home Phone: _____ Alternate/Cell Phone: _____

Work Phone: _____

DOB: ___/___/___ Soc. Sec. No. _____ - _____ - _____

Gender: _ Male _ Female

Marital Status: _ Single _ Married _ Widowed _ Separated _ Divorced

Insurance (Responsible Party) Information:

Policy Holder Name: _____ (if not yourself)

DOB: ___/___/___ (policy holder's date of birth)

Policy Holder's Employer: _____

Phone: _____

Insurance Information: (Information in box not required if card copied by office)

Insurance Name: _____ ID #: _____

Group #: _____

Claims Address: _____

Phone: _____

Emergency Contact Information

Name: _____ Phone Number: _____

Relationship: _____

How did you hear about us? (Please Select One)

Insurance Company Book or Website Plano Profile Magazine Referred by friend

Referred by Physician (please list name): _____

other (please specify): _____

May we use email to communicate with you? If yes, please list your email address below:

The above information is true and correct to the best of my knowledge.

Patient Signature: _____