DEBORAH WESTERGAARD M.D.

9301 N. Central Expy, Suite 115, Dallas, Texas 75231 ph. 214 750 6200

New Patient Information / IntakeSheet

Date: _____ Home Phone: _____ Work Phone: _____

Patient Name: _____

Chief Complaint: _____

_____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

SS#: _____ Age: _____ DOB: _____ Sex: Male Female

Email: _____

Referred by: _____ Phone: _____

Spouses Name: _____ DOB: _____ SS#: _____

Employer: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance: _____ Member ID: _____

Group #: _____ Insured Person: _____ Insured SS#: _____

Secondary Insurance: _____ Member ID: _____

Group #: _____ Insured Person: _____ Insured SS#: _____

Is this a work related injury? **YES** **NO**

Compensable Injury: _____ Date of Injury: _____

W/C Carrier: _____ Claim #: _____ Phone: _____

Contact in Case of Emergency: _____ Phone: _____

Authorizations: I hereby authorize Deborah Westergaard, M.D. permission to treat myself / my dependents and to furnish information to my insurance carriers and / or attorneys, concerning my illness and treatments.

Signature of Patient / Guarantor: _____ Date: _____