Texas Rheumatology

Deepika Arora, MD
Hema Salvady, MD
Prashanth Sunkureddi, MD
Dany Thekkemuriyil, MD
Heather Mambretti, PA-C

Patient Information

Date: _____

Patient Name: _____ SSN#: _____
Last Name First Name Middle Initial (Optional)

DOB: _____/_____/_____ Age: _____ Sex: M / F

Preferred Phone: _____ Alt Phone:_____
Circle Type: (cell/home/work) (cell/home/work)

Address: _____ E-mail: _____

City: _____ State: _____ Zip:_____

Insurance Information

Primary Insurance: _____ ID: _____ Group Number: _____

Secondary Insurance: _____ ID: _____ Group Number: _____

Pharmacy Information

Retail Pharmacy: _____ Location: _____

Mail Order Pharmacy: _____ Location: _____

Family and Friends

Please list your family or friends with whom we may share your information.

_____ _____ _____

Physicians / Other Providers

Please list your physicians or other providers with whom we may share your information.

_____ _____ _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Patient Consent Regarding the Disclosure of Information

I have been given the opportunity to read the Notice of Privacy Practices and have had my questions answered by this office.

_____ _____
Patient Name Signature (Patient/Parent/Guardian)