PAMELA M. CARR, MD.PA.
1111 HWY 6 SUITE 160
SUGAR LAND, TEXAS 77478

PRIVATE AND CONFIDENTIAL PATIENT INFORMATION RECORD

THANK YOU FOR CHOOSING OUR OFFICE! IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION. ALL INFORMATION WILL BE CONFIDENTIAL!
PLEASE INFORM FRONT DESK IF YOU HAVE MEDICARE OR MEDICAID.

PLEASE FILL OUT THE FOLLOWING INFORMATION AND ***SIGN*** **BELOW**.
IF YOU ARE A MINOR YOU MUST BE ACCOMPANIED BY GUARDIAN: (PLEASE PRINT)

PATIENT INFORMATION

Name:_____ _____ _____ _____
LAST *MIDDLE INT .* *FIRST* *(NICK NAME)*

Marital Status (PLEASE CIRCLE): S M W D SEP Birthdate:_____
Address:_____City:_____State:_____Zip:_____
Mailing address:_____City:_____State:_____Zip:_____
Home Phone Number:( )_____Wk Phone Number:( )_____
Other:( )_____ S.S. #_____-_____-_____ Age:_____
☐ Male ☐ Female Patient's Drivers Lic.#_____
Patient's Employer:_____
Employer's Address:_____City:_____State:_____Zip:_____
Whom may we thank for referring you:_____
Name of Nearest Friend/Relative(Not living with Patient):_____
Relationship to patient:_____Phone #:( )_____
Address:_____City:_____State:_____Zip:_____
LIST ANY DRUG ALLERGIES:_____

IF PATIENT IS A MINOR OR STUDENT (PLEASE FILL IN BOTTOM PORTION)

Mother's Name:_____ _____ _____
LAST *MID.INT.* *FIRST*

ADDRESS:(If different from patient's)_____
Hm Phone # (If different from patient's):( )_____Birthdate:_____
Wk Number: ( )_____S.S. # _____Occupation:_____
Employer:_____Employer's Address:_____

Father's Name:_____ _____ _____
LAST *MID.INT.* *FIRST*

ADDDRESS:(If different from patient's)_____
Hm Phone # (If different from patient's): ( )_____Birthdate:_____
Wk Number: ( )_____ S.S. #_____Occupation:_____
Employer:_____Employer's Adddress:_____

The patient is responsible for all charges resulting from professional service rendered by the physician. It is customary to pay for services when rendered. Dr. Carr's office is not affiliated with any insurance plans. If you have any questions, please ask the front office. I authorize Dr. Carr to release any information concerning my (or my child) health care, advice and treatment as stated in the Health Information Notice:

_____ _____
SIGNATURE OF PATIENT /(IF UNDER 18 SIGNATURE OF GUARDIAN) DATE