

**PATIENT INFORMATION QUESTIONNAIRE**

Patient Name: \_\_\_\_\_ Sex: M F  
*Last, First, Middle* Birthdate: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
*Street Address (Include apartment number if applicable)*

\_\_\_\_\_ Social Security: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
*City, State, Zip Code*

Patient's Telephone: Home # \_\_\_\_\_  
Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Patient's Employer Name & Address: \_\_\_\_\_

Patient Email Address: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
*May we use this email to send you special offers? Y N Include Name and Phone Number*

**COMPLETE THE FOLLOWING ONLY IF DIFFERENT FROM PATIENT INFORMATION**

Responsible Party Name: \_\_\_\_\_  
*Last, First, Middle*

Responsible Party Address: \_\_\_\_\_  
*Street Address (Include apartment number if applicable)*

\_\_\_\_\_ Social Security: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
*City, State, Zip Code*

Telephone: Home# \_\_\_\_\_ Work# \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_

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Southwestern Bell Yellow Pages: Houston Book Pasadena Book Clear Lake Book  
Bay Area Houston Magazine Change Magazine

Another Patient: (please give name) \_\_\_\_\_

Another Physician (Please give name): \_\_\_\_\_

Website: [www.drmoliver.com](http://www.drmoliver.com)

Other (please specify) \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to Clayton L. Moliver, M.D.  
for any surgical and/or medical benefits otherwise payable to me for his services.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I hereby authorize Clayton L. Moliver, M.D. to release  
any information acquired during the course of my examination and treatment.

Signature \_\_\_\_\_ Date: \_\_\_\_\_