

**Primary Care Internal Medicine, P.L.L.C.  
Mark Doerner, M.D., Ph.D.**

**PATIENT REGISTRATION**

**Personal Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip Code

Social Security #: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Treatment and Payment Agreement**

I authorize examination and treatment for this and all following physician visits.  
I authorize release of any medical information necessary to process any insurance billings.  
I authorize payment and assignment of insurance benefits to Primary Care Internal Medicine, PLLC.  
I understand I am financially responsible for all charges and deductibles not covered by my insurance.  
I am personally responsible for supplying accurate and current insurance information.  
I authorize a photocopy of this statement to serve as an original.

\_\_\_\_\_  
Patient Signature (Parent or Guardian if patient is under age 18) Date

\_\_\_\_\_  
Parent/Guardian Printed Name (If patient is under age 18)



## Primary Care Internal Medicine, P.L.L.C.

Mark Doerner, M.D.

1111 Raintree Circle, Suite 240  
Allen, TX 75013  
Tel (972) 908-3455  
Fax (972) 908-3477

### AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

#### PATIENT INFORMATION (Please Print):

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

#### RELEASE MY MEDICAL RECORDS FROM:

Name: \_\_\_\_\_

Tel: \_\_\_\_\_

Fax: \_\_\_\_\_

TO:

Mark Doerner, M.D.  
Primary Care Internal Medicine, P.L.L.C.  
1111 Raintree Circle, Suite 240  
Allen, Texas 75013

Phone: 972-908-3455  
Fax: 972-908-3477

Please send medical records no later than: \_\_\_\_\_

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

*Signature*

## PHARMACY INFORMATION

We now have electronic prescribing. Please complete the form below with your pharmacy information so that we may send your prescriptions electronically. If you use more than one pharmacy, such as a local pharmacy and a mail-order pharmacy, please list both pharmacies.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1) Pharmacy Name \_\_\_\_\_

Pharmacy Location \_\_\_\_\_  
Street City State

Pharmacy Phone Number \_\_\_\_\_

2) Pharmacy Name \_\_\_\_\_

Pharmacy Location \_\_\_\_\_  
Street City State

Pharmacy Phone Number \_\_\_\_\_