La Grange | Flatonia | Giddings
Family Health Centers

William Michael McBroom, M.D. Thomas O. Borgstedte, D.O. Wess J. Blackwell, M.D.

La Grange	Flatonia	Giddings
O: (979) 968-8493	O: (361) 865-3302	O: (979)542-7400
F: (979) 968-6388	F: (361) 865-3631	F: (979) 542-3031
1253 N Von Minden	230 W North Main	598 Cactus St
La Grange, TX 78945	Flatonia, TX 78941	Giddings, TX 78942

DOT PACKET

PATIENT INFORMATION

NAME:	DATE OF BIRTH:	☐ MALE ☐ FEMALE
PREFERRED CONTACT: ☐ CELL ☐ HOME ☐ WORK	#:	#:
EMAIL:	SSN:	DRIVERS LIC:
ADDRESS: CITY: STATE: ZIP CODE:		
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	RACE: ☐ CAUCASIAN/WHITE ☐ AFRICAN AMERICAN/BLACK ☐ HISPANIC ☐ ASIAN ☐ OTHER	

GUARANTOR INFORMATION (SKIP IF THE PATIENT IS THE GUARANTOR)

GUARANTOR NAME:		DATE OF BIRTH:	
MAILING ADDRESS:	CITY:	STATE:	ZIP:
RELATIONSHIP TO PATIENT:	SSN:		
CELL#:	HOME#:	ALT#:	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:		
GROUP #:	POLICY #:	
POLICY HOLDER:	DATE OF BIRTH:	SSN:
SECONDARY INSURANCE COMPANY:		
GROUP #:	POLICY #:	
POLICY HOLDER:	DATE OF BIRTH:	SSN:

EMERGENCY CONTACT

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

**Family Health Center files insurance as a courtesy to our patients. It is the sole responsibility of the patient/guarantor to verify that the Provider and/or service they receive here are covered by their insurance/payor. Payment is due at the time services are rendered including any copay/coinsurance/deductible portions.

I, ___________________________________ (Self/Guardian/Guarantor) have read the following material; Office, Insurance, and Payment Policy and the Notice of Privacy Practices, presented to me by Family Health Center and I understand my responsibilities as the Patient/Guardian/Guarantor of this facility and that all of the information provided on this form is true and correct.

SIGNATURE: ____ Date: ___________________________________

PRINT NAME: ____ Relationship if not self: _____________________