JOHN H. ROFF, M.D., P.A.

18220 State Highway 249, Suite 320
Houston, TX 77070
281-807-6676

Date:________________

Section I **Patient Information**

Name:____ Date of Birth:____________________

Social Security Number:________________________

Address:_______________________________________City:______________State:_______Zip:_____

Phone:____________________ ☐ Home ☐ Cell ☐ Work Alternate Phone: __________________

Email Address:______________________________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student: ☐ FT ☐ PT Spouse or Parent's Name:____________________________

Person to contact in case of emergency:__________________________Phone:___________________

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:______________________________________

Date of Birth:_______________ Social Security Number:________________________

Address:____

City:______________________________ State:__________ Zip:_________Phone:_________________

Section III **Insurance Information (Please complete or allow us to copy your card)**

Name of Insured:___________________________DOB:___________SSN#:_____________________

Insurance Company:________________________Group #:__________ ID#:____________________

Ins Co Address:__________________________________Ins Co Phone:_______________________

Name of Employer:_____________________ Work Phone:__________________

Address of Employer:__________________________City:_____________State:_____Zip: _________

-------DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No

Section IV

Whom may we thank for referring you?____

Your Age _____ Height _____ Weight _____ Male _____ Female _____

Reason for Seeing Dr. Roff today:

____

____