



West Houston
Internal Medicine Associates PA.

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PATIENT INFORMATION

Patient Name		Patient Address			Marital Status
City	State	Zip	Texas Driver License #	Birth date	Sex
Home Telephone #		Cellular Phone #		Work Telephone #	
Email		SS#		Occupation	
Employer Name		Employer Address			

SUBSCRIBER (Person whom the insurance is provided through)

Patient Name			Relationship to Patient	Birth date	
Texas Drivers License #	Sex	Birth date	Cell Phone #	Work Phone #	Home Phone
Name of Employer			Occupation	SS#	
Address			City	State	Zip

EMERGENCY NOTIFICATION (Someone not living at the same address)

Name		Address		City/State	
Home Telephone	Cellular Phone #			Work Phone #	Relationship
Name		Address		City/State	
Home Telephone	Cellular Phone #			Work Phone #	Relationship

PRIMARY HEALTH INSURANCE

Name of Insurance		Policy #	Group #	Copay \$
Name of Employer		Address		City/State

SECONDARY HEALTH INSURANCE

Name of Insurance		Policy #	Group #	Copay \$
Name of Employer		Address		City/State

I hereby authorize any physician, hospital, insurer or other organization or person having any records, data or information concerning health history or other insurance for me or my dependents, to furnish such records, data or information as may be requested by Insurance or their duty authorized representative. A photocopy of this authorization shall be considered as effective and valid as the original.

If the provider is sending insurance claims directly to the insurance company or intermediaries, this constitutes my authorization to pay benefits directly to the provider and my authorization to release information for insurance purposes.

PATIENT / LEGAL GUARDIAN'S SIGNATURE **DATE**

PATIENT / LEGAL GUARDIAN'S SIGNATURE **DATE**

I hereby state that I have received a HIPPA Privacy & Compliance Form. It further notes that I have read and understood the form.

PATIENT / LEGAL GUARDIAN'S SIGNATURE & DATE