Charles A. Evans M.D., PhD, PA
203 Christie St.
Lufkin, Texas 75904
936-699-5433
FAX: 936-699-5465

PATIENT INFORMATION

First Name: _____ **MI:**___ **Last Name:** _____

Circle One: Mr. / Ms. **Marital Status:** circle one Single / Married / Divorced / Separated / Widowed

DOB: ___/___/_____ **Social Security #:** _____/____/_____ **Sex:** Male/Female/Other

Street Address:_____

City: _____**State:** _____ **Zip:** _____

Number Where You Can Be Reached: _____/_____/_____

Secondary Phone Number: _____/_____/_____

EMAIL ADDRESS:_____

Employer _____

Employer's Phone Number: _____/_____/_____

Guarantor's Information if Other than Patient or if Patient is a Minor

Policy Holder Name:

DOB:___/___/_____ **Social Security #:** _____/_____/_____

Street Address:_____

City: _____**State:** _____ **Zip:** _____

Number Where You Can Be Reached: _____/_____/_____

Emergency Contact Information

Name_____ **Relation to Patient** _____

Phone Number: _____/_____/_____

Secondary Emergency Contact Information

Name_____ **Relation to Patient** _____

Phone Number: _____/_____/_____

Authorization to Release Information

Check here if you do not want anyone other than yourself to receive information. _____

Name of designated persons you may receive your information, their relationship to you, and their phone number.

Name: _____ Relation to Patient: _____

Phone Number: _____/_____/_____

Name: _____ Relation to Patient: _____

Phone Number: _____/_____/_____

Please allow 1 BUSINESS DAY for Medication Refills.

Please list your pharmacy's name, address and phone number.

Name: _____

Address: _____

Phone Number: _____/_____/_____

If you need to cancel or reschedule your appointment, please call our office within 24 hours prior to your appointment time.

PLEASE NOTE!

If you do not show up for your appointment without prior notice, you will be charged **$25**.

If you do not show up for you lab results appointment without prior notice, you will be charged **$100**.

Please note that lab results appointments take at least an hour.

I acknowledge that I was provided a copy of this clinic's privacy practices, and that I have had the opportunity to read it if I so choose. I understand the notice. I acknowledge that I am responsible for following my physician's and/or practitioner's recommendations, and I understand that the sole responsibility of my health and well-being is in my hands. In view of the above, I cannot hold my physician and/or practitioners responsible if I do not adhere to his/her recommendations and/or take make lifestyle changes and take medications as I am instructed to do.

Signature _____ Date _____

The Institute for Lifestyle, Preventive and Family Medicine

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