

C.C. Hutton, MD
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936-539-5000 metro 936-441-0226 fax 936-539-5027

Patient's full name _____ Age _____ Birth date _____
(last) (first) (MI)

Social security #: _____ Spouse's name: _____

Email: _____

Home #: _____ Cell #: _____ Work #: _____

Complete mailing address: _____
(street) (city) (zip)

Nearest relative NOT living with you: _____
(name) (phone #) (relationship)

Primary insurance: _____
(Medicare) (Medicaid) (Blue Cross) (Texas Health Spring)

Other primary: _____
(name, address, phone #) (ID/Policy #)

Secondary insurance: _____
(name, address, phone #) (ID/Policy #)

Today's date: _____ Referred by: _____

Current medications: _____

All known medication allergies: _____

Do you currently smoke? _____ YES / amount: _____

_____ NO / never, or when stopped: _____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge. I hereby authorize C.C. Hutton, MD, to release any information acquired in the course of my examination and/or treatment for insurance purposes. I hereby authorize any payment of medical or surgical benefits to be paid directly to the above named physician for his service. I understand that financial responsibility for any charges not covered by this authorization. A photo static/fax copy of this authorization may be exhibited as proof of my consent.

Patient or responsible party: _____