

**GHASSAN N. FANOUS, M.D.**

540 West 5th Street, Suite 420 Odessa, Texas 79761  
(432) 582-2280

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Place of employment \_\_\_\_\_

Insurance Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

E-mail Address (If convenient to receive information via e-mail) \_\_\_\_\_

Would you like to make any changes to your HIPPA form? (circle one) Yes or No

**Please provide a current copy of you insurance card and remember that insurance is not a substitution for co-payments. If you do not present your current card then you will be responsible for the charges.**

**I hereby authorize Dr. Fanous to furnish information to insurance carriers concerning any illness and treatments and I assign to Dr. Fanous all payments for medical services rendered to me. I understand that I am responsible for any amount not covered by insurance.**

\_\_\_\_\_

**Signature**

\_\_\_\_\_

**Date**