DEBORAH WESTERGAARD M.D.
9301 N. Central Expy, Suite 115, Dallas, Texas 75231 ph. 214 750 6200

New Patient Information / IntakeSheet

Date: ____________ Home Phone: ________________________ Work Phone: __________________________

Patient Name: ____

Chief Complaint: ____

____

Address: ______________________________________ Apt: __________

City: ______________________________ State: ________ Zip: __________

SS#: ______________________ Age: __________ DOB: ____________ Sex: ◯ Male ◯ Female

Email: ____

Referred by: ______________________________ Phone: ______________

Spouses Name: ________________________ DOB: ____________ SS#: ______________

Employer: ______________________________ Phone: ______________

Address: ____

City: ______________________________ State: ________ Zip: __________

Primary Insurance: ____________________________ Member ID: ______________

Group #: ______________ Insured Person: ______________ Insured SS#: ______________

Secondary Insurance: ____________________________ Member ID: ______________

Group #: ______________ Insured Person: ______________ Insured SS#: ______________

Is this a work related injury? ◯ **YES** ◯ **NO**

Compensable Injury: ______________________________ Date of Injury: ______________

W/C Carrier: ____________________ Claim #: ______________ Phone: ______________

Contact in Case of Emergency: ________________________ Phone: ______________

Authorizations: I hereby authorize Deborah Westergaard, M.D. permission to treat myself / my dependents and to furnish information to my insurance carriers and / or attorneys, concerning my illness and treatments.

Signature of Patient / Guarantor: ______________________________ Date: ______________