

Gabriel A. Maislos  
7737 Southwest Freeway, Suite 790  
Houston, TX 77074  
713-541-3199

Date \_\_\_\_\_

**Welcome to our Office!**

Who referred you to our office? \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_

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

Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security No \_\_\_\_\_

Driver's License \_\_\_\_\_ State \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone No \_\_\_\_\_

**Insurance Coverage**

Plan 1 Plan 2

Ins. Name \_\_\_\_\_ Ins. Name \_\_\_\_\_

Insured \_\_\_\_\_ Insured \_\_\_\_\_

Group No. \_\_\_\_\_ Group No. \_\_\_\_\_

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**Please sign authorizations below:**

**AUTHORIZATION OF BENEFITS TO PROVIDER:** I hereby assign and relinquish my interest in and title to my Insurance benefits to the physician/supplier listed above for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the physician/supplier indicated above to furnish information to insurance carriers concerning this illness/accident. I realize that my records may be electronically transmitted and through some default may not be received by the intended recipient. Should this occur, I release the physician/supplier from all liability.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR TREATMENT:** I consent for medical services and treatment from the physicians and staff of Dr. Gabriel A. Maislos, DPM

Signature \_\_\_\_\_ Date \_\_\_\_\_