NATIONAL FAMILY CARE LIFE INSURANCE COMPANY
P.O. BOX 809043 DALLAS, TEXAS 75380 (972) 387-8553

SAVE FORM TO COMPLETE

ATTENDING PHYSICIAN STATEMENT

SAVE FORM TO COMPLETE

PATIENT'S NAME	BIRTHDATE	ADDRESS Street _____ City ST Zip

PRIMARY DIAGNOSIS? (Must include ICD-9 Code)	
Date of Accident? (If applicable)	
Date patient first consulted you for this condition?	
Date patient first noted symptoms before consulting you?	
List medications patient has taken for this condition in past 2 years.	
Has patient received consultation or treatment for this condition in the past year?	
Has patient ever had same or similar condition? Yes◯ No◯. **If Yes, when and describe.**	
Please describe the pain (character, location, etc.) and the associated symptoms and findings (shock, dyspnea, arrythmia, failure, etc.).	
What special studies were made (ECG, X-ray, etc.)? When? What were the results?	
Date(s) of Hospital Confinement?	From _____ To _____ From _____ To _____ From _____ To _____ From _____ To _____
Is any medication being taken (digitalis, anti-coagulants, coronary dilator drugs, etc.)? **Yes◯ No◯** **If Yes, please supply type and dosage.**	

Date_____ Physician's Name_____ Degree_____

Address_____ _____ _____ _____
(Street) (City) (State) (Zip)

Telephone_____ **PHYSICIAN'S SIGNATURE**_____
Area Code & Number