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

PRINT FORM TO COMPLETE

ATTENDING PHYSICIAN STATEMENT

PRINT 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, arrhythmia, failure, etc.).	
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

NFCL 101 AP 12-81 / 2-14