Family Medical Center

at

Cinco Ranch

REGISTRATION INFORMATION

Date: _____

Home Phone: __ __ __-__ __ __-__ __ __ __

Patient:_____

Last Name First Name Middle Initial

Social Security #: __ __ __- __ __- __ __ __ __ Cell Phone:__ __ __- __ __ __- __ __ __ __

Responsible Party (if minor):_____Relationship:_____

Street Address: _____

City: _____ State: _____ Zip Code: __ __ __ __ __

Sex: ☐ Male ☐ Female Age: _____ Birth Date:__ __/__ __/__ __ __ __

Employment: ☐ Employed ☐ Unemployed ☐ Student

Employer/School:

_____

Address: _____

Occupation: _____ Business/School Phone:__ __ __- __ __ __- __ __ __ __

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse (or responsible party) Name: _____

Birthdate: __ __/__ __/__ __ __ __ Social Security #: __ __ __- __ __- __ __ __ __

Occupation: _____ Business Phone:__ __ __- __ __ __- __ __ __ __

Business Address:_____

Home Address (if different):_____

Home Phone (if different): __ __ __- __ __ __- __ __ __ __

Emergency Contact:_____ Phone:__ __ __- __ __ __- __ __ __ __

Do you have medical insurance? ☐ yes ☐ no

Name of Primary Insurance:_____

Address: _____

Name of Subscriber: _____Contact #:__ __ __- __ __ __- __ __ __ __

Plan/Group #:_____ ID#: _____

Name of Secondary Insurance:_____

Address: _____

Name of Subscriber: _____Contact #:__ __ __- __ __ __- __ __ __ __

Plan/Group #: _____ ID#: _____

I authorize Shelley C. Ferrill, M.D. and the staff of Family Medical Center at Cinco Ranch to release any information obtained in the course of my treatment to my insurance company, employer, or third party payer as required of filing claims, quality assurance, health plan administration, and complaints/grievances. I authorize direct payment to be made to Shelley C. Ferrill, M.D. of Family Medical Center at Cinco Ranch for any and all medical services rendered. I understand that if any services or charges are not covered, or if Family Medical Center at Cinco Ranch is unable to verify eligibility, I am responsible for all charges incurred for services rendered.

Patient/Guarantor Signature: _____ Date:_____