New Patient Registration

Patient Information:

Name:_____ **Date of Birth:**_____
First Middle Initial Last

Student? ☐ Yes ☐ No

Address: _____ **Sex**: ☐ Male ☐ Female

_____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____

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

Emergency Contact: _____ Phone: _____

Financially Responsible Party Information:

☐ Same as above

Name:_____ **Date of Birth:**_____
First Middle Initial Last

Address: _____ **Sex:** ☐ Male ☐ Female

_____

Phone: _____ **Relationship to Patient:** _____

Email: _____

Primary Insurance Information:

☐ No insurance

Policy Holder Name: _____ **Date of Birth:**_____
First Middle Initial Last

Relationship to patient: _____ **Employer:** _____

Insurance Company Name: _____

Address: _____

_____

Policy/ID #: _____ **Group #:** _____

Secondary Insurance Information:

Policy Holder Name: _____ **Date of Birth:**_____
First Middle Initial Last

Relationship to patient: _____ **Employer:** _____

Insurance Company Name: _____

Address: _____

_____

Policy/ID #: _____ **Group #:** _____

The above information is true to the best of my knowledge. I hereby assign, transfer, and set over to Family Medical Center at Cinco Ranch all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/ government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company. I appoint Family Medical Center at Cinco Ranch to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____ _____

Patient/Guardian Signature Date