

PATIENT REGISTRATION FORM

*Family Medical Center at Garland
 Family Medical Center at North Garland
 Family Medical Center at Wylie*

FOR OFFICE USE ONLY Acct # _____

Today's Date: _____

Patient Information

Full Name: Last	First	Middle	(Maiden)
Address: (Street or Box)		City	State Zip
Home Phone # ()	Work Phone # ()	Cell Phone # ()	Email Address
Referred By:	Date of Birth	Age	Sex (circle one) Male Female
Occupation	Employer	Employer Address	
Marital Status (circle one) Single Married Widowed Divorced Separated	Spouse's Name		Race (circle one) American Indian Asian Black Hispanic White Other
If Student, Indicate School	If Patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation required):		
Emergency Contact (not living at same address)		Emergency Contact Phone # ()	

Responsible Party

Guarantor Full Name: Last	First	Middle	(Maiden)
Address: (Street or Box)		City	State Zip
Home Phone # ()	Work Phone # ()	Cell Phone # ()	Drivers License #
Date of Birth	Age	Sex (circle one) Male Female	Social Security # Patient Relationship to Guarantor
Employer	Employer Address		

Insurance Information

Name of Primary Insurance Company 1.	Phone # ()	Name of Secondary Insurance Company 2.	Phone # ()
Mailing Address		Mailing Address	
City	State Zip	City	State Zip
Policy Number	Group Number	Effective Dates of Policy From: To:	Policy Number Group Number Effective Dates of Policy From: To:
Policy Holder (if other than patient)	Date of Birth	Policy Holder (if other than patient)	Date of Birth
Social Security #	Relationship to Patient	Social Security #	Relationship to Patient
Policy Holder's Employer	Work Phone # ()	Policy Holder's Employer	Work Phone # ()
Employer Address		Employer Address	
City	State Zip	City	State Zip

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Accident / Workers Comp

Insurance Company	Phone # ()	
Mailing Address		
City	State	Zip
Effective Dates of Policy From:	Date of Accident / Onset	Due To: (circle one) Auto accident Work injury / illness
To:		Other
Agent / Adjuster / Case Manager		
If Workers Comp: Claim #	TWCC Claim #	

Consent to Treat

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

If patient is a minor:
I consent for _____ to authorize evaluation and treatment for my child named
(Name(s): First & Last)
herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Signature of Patient, Parent, or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas (hereinafter "HT") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to HT. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HT, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Signature of Patient, Parent, or Legal Guardian **Date**