REGISTRATION

(PLEASE PRINT)

2202-B West Alabama, Houston, TX 77098

713.528.4440 Fax: 713.528.4447

Date_____ Home Phone (_____) _____ Cell Phone: (____) _____

PATIENT INFORMATION

Name _____ SS / HIC / Patient ID# _____

Last name First Name Middle Initial

Address _____ Email _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Married Widowed Single Minor

Separated Divorced Partnered for ____ years

Patient Employer / School _____ Occupation _____

Employer / School Address _____ Employer / School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (_____) _____

PRIMARY INSURANCE

Person Responsible for Account _____

Last name First Name Middle Initial

Relation to Patient _____ Birthdate _____ SSN# _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone: (____) _____

Insurance Company _____

Contract# _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan: _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone: (____) _____

Insurance Company _____ SSN# _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with (name of insurance) _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date