

Family Health Pro
Medical Clinic
602 Lawrence St
Tomball, TX 77375

PATIENT REGISTRATION

Please fill out form then press the print button above or print this form then fill out by hand printing your information legibly.

PATIENT NAME (LAST, FIRST, MIDDLE): _____

DOB: _____ AGE: _____ SEX: Male Female

STREET: _____ CITY: _____ ST/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY NUMBER: _____

EMPLOYER NAME: _____ OCCUPATION: _____

WORK PHONE: _____

MARITAL STATUS: _____ SPOUSE NAME: _____

SPOUSE SOCIAL SECURITY: _____ SPOUSE DOB: _____

PRIMARY INSURANCE INFO

INSURANCE NAME: _____ PHONE: _____

INS. ADDRESS: _____ CITY: _____ ST/ZIP: _____

INSURED/SUBSCRIBER NAME: _____ RELATIONSHIP: _____

SUBSCRIBER ID#: _____ GROUP #: _____

SECONDARY INSURANCE INFO

INSURANCE NAME: _____ PHONE: _____

INS. ADDRESS: _____ CITY: _____ ST/ZIP: _____

INSURED/SUBSCRIBER NAME: _____ RELATIONSHIP: _____

SUBSCRIBER ID#: _____ GROUP #: _____

ADDITIONAL BILLING INFORMATION

PERSON RESPONSIBLE FOR BILLS (OTHER THAN ABOVE): _____

RELATIONSHIP: _____ PHONE: _____

NEAREST RELATIVE NOT LIVING WITH PATIENT: _____

ADDRESS/PHONE#: _____

FOR CONFIDENTIALITY PURPOSES, WE WOULD LIKE YOU TO INDICATE WHAT PHONE NUMBER WE MAY CONTACT YOU AT:

HOME WORK CELL DO YOU PREFER: DETAILED MESSAGE BRIEF MESSAGE

I give Family Health Pro Clinic and its staff permission to contact me at the above phone number:

Signature: _____ Date: _____
(patient, parent or guardian)

Print Name: _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I certify that the above information is correct to the best of my knowledge. I hereby authorize payment of benefits directly to TOMBALL PRIMARY CARE, P.A.. I understand that I have a contract with my insurance company and it is my responsibility to understand my benefits and how my plan works. VERIFICATION OF YOUR BENEFITS IS NOT A GUARANTEE OF PAYMENT AS QUOTED BY YOUR HEALTH PLAN. I understand that legally my insurance has 45 days to pay claims at which point I may be billed in full. I also understand that I am financially responsible for all charges whether or not covered by insurance.

Signature _____ Date _____

I hereby authorize the undersigned Provider to release medical records or any information necessary to process this or any future claim in the course of my examination or treatment.

Signature _____ Date _____

Provider: , George A Valdez, MD

PAYMENT IS REQUIRED AT THE TIME OF SERVICES OR TREATMENT IS RENDERED.

REFERRED BY:

- Physician
- Other Patient/Friend
- Emergency Dept.
- HEB Rediclinic
- Insurance
- Newspaper Ad
- Yellow Page