

Patient Registration Form

(Please Print)

PATIENT INFORMATION

Patient's Name (Last) _____ (First) _____ (Middle) _____

Marital Status Married Single Divorced Widowed Legally Separated Other

Social Security Number _____ - _____ - _____ Female Male Date of Birth _____ / _____ / _____

E-Mail Address _____

Phone Numbers Work _____ Day Evening Home _____ Day Evening
Cellular _____ Pager _____

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Emergency Contact Relationship to Patient _____

Referring Provider Name/PCP _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insured Employer Name _____

Insurance Company/Phone Number _____ (_____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth _____ / _____ / _____ Insured's Social Security Number _____ - _____ - _____

Insurance Company Address _____

ASSIGNMENT OF BENEFITS

I hereby assign **PRIMARY HEALTH NETWORK OF SOUTH TEXAS DBA DR. HAMMILL** any insurance or other third-party benefits available for health care services provided to me. I understand **PRIMARY HEALTH NETWORK OF SOUTH TEXAS DBA DR. HAMMILL** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **PRIMARY HEALTH NETWORK OF SOUTH TEXAS DBA DR. HAMMILL**, I agree to forward to **PRIMARY HEALTH NETWORK OF SOUTH TEXAS DBA DR. HAMMILL** all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____

Date: _____

NOTICE OF PRIVACY PRACTICE

I acknowledge receipt of this Notice of Privacy Rights which I have reviewed and give my permission to **PRIMARY HEALTH NETWORK OF SOUTH TEXAS DBA DR. HAMMILL** to use and disclose my health information with it and only as needed.

Patient Name: _____ Signature: _____

Date: _____ Signature of Legal Guardian: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____