

Patient Information

As listed on insurance

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: Male Female

If *actual* name, DOB, or gender is different than insurance records:

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: Male Female

Mailing Address: _____ Apt/Suite #: _____
City: _____ State: _____ Zip Code: _____ - _____
Social Security Number: _____ - _____ - _____

Home Phone: _____ *Cell Phone: _____
Work/Alternate Phone: _____ extension: _____

eMessenger Preferences

Circle One: Morning Afternoon Evening
Circle One: Home *Cell Work/Alternate
*If you prefer text messages, initial here _____.
*Standard text messaging rates apply

Acknowledgements, Authorizations and Assignment of Benefits

As a courtesy to our patients and at your request, we will be happy to file charges for your office visit with your Insurance Company. Please be aware that verification of benefits and filing of a claim DOES NOT GUARANTEE PAYMENT. The determination of whether the bill is paid is made by the Insurance Company when they receive the bill.

I hereby authorize East Houston Medical Group to release to my Medical Insurance Company or its representatives any information requested by them including the diagnosis and the records of my treatment or examination performed on me. Furthermore, I authorize my Insurance Company to pay all medical benefits directly to East Houston Medical Group for services provided to me or my dependent(s). If for any reason my Insurance Company fails to make payment on my behalf within 120 days, I agree to pay the balance of my account in full without delay. I hereby certify that I DO NOT have any other Medical Insurance Coverage other than: _____.

I hereby authorize East Houston Medical Group to treat my medical conditions.

I acknowledge that the HIPAA privacy notice has been made available to me and that a copy will be given to me upon my request.

I understand that I may be charged for missed appointments and other administrative fees.

Parent/Guardian Signature: _____ Date: _____

Preferred Pharmacy

Local Pharmacy Name: _____	Mail Order Pharmacy: _____
Address or Location: _____	Address or Location: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
	Pharmacy Member ID: _____

May we communicate electronically with pharmacies regarding your past and current prescription records? Circle One: Yes No

Government regulations require us to document how patients identify their own **race and ethnicity**. **Please select one choice from each list.**

Race:

American Indian or Alaska Native _____
Asian _____
Native Hawaiian or Other Pacific Islander _____
Black or African American _____
White _____
Hispanic _____
Other Race _____
Other Pacific Islander _____
Unreported/Refused to Report _____

Ethnicity:

Hispanic or Latino _____
Non-hispanic or Latino _____
Refused to Report _____

Please tell us how you heard about us:

_____ Internet
_____ Newspaper
_____ Employer, Please specify _____
_____ Friend / Family Member, Please specify _____
_____ Drove by / saw the sign
_____ Other

Parent/Guardian Signature: _____ Date: _____

If address/phone is same as patient, you may leave it blank

Parent/Guardian One

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt/Suite #: _____

City: _____ State: _____ Zip Code: _____ - _____

Primary Phone: _____ Alternate Phone: _____

Work Phone: _____ extension: _____

Date of Birth: _____ Sex: Male Female

Social Security Number: _____ - _____ - _____

Driver License Number: _____ Issuing State: _____

e-mail address: _____

Relationship to Child: Natural Parent Step Parent Grandparent Sibling Other: _____

If address/phone is same as patient, you may leave it blank

Parent/Guardian Two

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt/Suite #: _____

City: _____ State: _____ Zip Code: _____ - _____

Primary Phone: _____ Alternate Phone: _____

Work Phone: _____ extension: _____

Date of Birth: _____ Sex: Male Female

Social Security Number: _____ - _____ - _____

Driver License Number: _____ Issuing State: _____

Relationship to Child: Natural Parent Step Parent Grandparent Sibling Other: _____

Insurance Information

Primary Carrier

Company Name: _____ Phone: _____

ID Number: _____ Group Number: _____

Main Insured: Self Parent/Guardian One Parent/Guardian Two *Other

*if you choose Other, please fill in Main Insured Information below

Secondary Carrier

Company Name: _____ Phone: _____

ID Number: _____ Group Number: _____

Main Insured: Self Parent/Guardian One Parent/Guardian Two *Other

*if you choose Other, please fill in Main Insured Information below

Main Insured Information

Last Name: _____ First Name: _____ MI: _____

Relationship to patient: _____ Date of Birth: _____ Sex: Male Female

Social Security Number: _____ - _____ - _____

Parent/Guardian Signature: _____ Date: _____

Emergency Contact Information

(other than Parent/Guardian)

This person will only be contacted if we are unable to contact you regarding an urgent matter, or if you have a medical emergency while in our office.

Last Name: _____ First Name: _____
Relationship to Patient: _____
Street Address: _____ Apt/Suite #: _____
City: _____ State: _____ Zip Code: _____ - _____
Primary Phone: _____ Alternate Phone: _____
Work Phone: _____ extension: _____

Proxy

The following individuals can consent for medical examination, vaccinations, and blood draws if a parent/guardian is not able to accompany the minor child to an appointment. These individuals must be 18 or older and present a valid photo ID at the front desk. (Parent/Guardian should not be listed again)

_____ Initial here to make the emergency contact a proxy

Last Name: _____ First Name: _____
Relationship to Patient: _____
Primary Phone: _____ Alternate Phone: _____

Last Name: _____ First Name: _____
Relationship to Patient: _____
Primary Phone: _____ Alternate Phone: _____

Last Name: _____ First Name: _____
Relationship to Patient: _____
Primary Phone: _____ Alternate Phone: _____

Last Name: _____ First Name: _____
Relationship to Patient: _____
Primary Phone: _____ Alternate Phone: _____

Please list any siblings that are also patients at our office:

Last Name: _____	First Name: _____	DOB: _____
Last Name: _____	First Name: _____	DOB: _____
Last Name: _____	First Name: _____	DOB: _____
Last Name: _____	First Name: _____	DOB: _____
Last Name: _____	First Name: _____	DOB: _____
Last Name: _____	First Name: _____	DOB: _____

WILL DELETE AFTER WE TELL EVERYONE:put language in 2 places, messenger and additional info

Parent/Guardian Signature: _____ Date: _____