

PATIENT REGISTRATION INFORMATION

Name: _____ Social Security #: _____
Marital Status: M ___ S ___ W ___ D ___ Sep ___ Sex: M ___ F ___ Date of Birth: _____ Full Time student? Yes ___ No ___
Race: _____ Ethnicity: _____ Preferred Language: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone _____ Work/Daytime Phone: _____ Email: _____
Name of Employer: _____ Occupation _____
Address of Employer: _____
Preferred Pharmacy _____ Pharmacy Phone _____
Address _____ State _____ Zip _____
How did you hear about us? ___ Friend ___ Newspaper ___ Radio ___ Billboard ___ Other ___
Would you be interested in receiving emails regarding our Research Studies? Yes ___ No ___

OTHER REGISTRATION INFORMATION

If married:

Name of Spouse _____ Social Security # _____ Date of Birth _____
Name of Employer _____ Occupation _____
Address of Employer _____

If a child:

Father's Name _____ Social Security # _____ Date of Birth _____
Mother's Name _____ Social Security # _____ Date of Birth _____
Father's Employer _____ Work/Daytime Phone (_____) _____
Address of Employer _____ Occupation _____
Mother's Employer _____ Work/Daytime Phone (_____) _____
Address of Employer _____ Occupation _____

CLOSEST RELATIVE OR FRIEND IN CASE OF EMERGENCY

Name: _____ Relationship to Patient _____
Address: Street _____ Phone: _____
City _____ State _____ Zip _____

HEALTH INSURANCE INFORMATION

INSURED: Name _____ Relationship to Patient _____
Marital Status: M ___ S ___ W ___ D ___ Sep ___ Social Security # _____ Date of Birth _____
Insured's Address _____
City _____ State _____ Zip _____
Home Phone (_____) _____ Work/Daytime Phone (_____) _____
Name of Insurance: _____ Telephone #: _____
Claims Address: _____
Effective date _____ Group # _____ Certificate # _____
Name of Employer Group _____ Primary Care Physician _____
Do you have other insurance? If yes, please provide information _____

I consent and authorize **HealthTexas Medical Group of San Antonio** to release all information contained in my financial and medical records to my insurance company or health plan, or any other person or entity that is responsible for paying or processing for payment any portion of my bill. I understand that I am totally responsible for payment of all fees and services rendered, regardless of insurance coverage or other responsibilities, and ultimately responsible for payment in full if my insurance company does not pay in a timely manner. I also understand that my prescription history from non-HTMG providers and pharmacies will be available to HTMG. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____