PATIENT REGISTRATION INFORMATION

Name: ______________________________________ Date of Birth: _____________ Social Security #: ____________________

Marital Status: M____S____W___D_____Sep____ Sex: M____F___Other (Please Specify)________________________________

Race: ____________ Ethnicity: _______________ Preferred Language: ______________ Full Time student? Yes___No_____

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

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: ____