



PATIENT INFORMATION

Name _____ Nickname _____ DOB _____ SS# _____
 Address _____ City _____ Zip _____
 Home _____ Work _____ Cell _____
 Sex: M F Married Divorced Single Minor Partnered for ___ years
 Patient employer/School _____ Occupation: _____
 Employer/School Address: _____
 Whom may we thank for referring you? _____
 In case of an emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____ Relation to Patient: Self Spouse Dependent
 DOB: _____ Soc.Sec.# _____ Phone _____
 Address (if different from patient) _____ City/State/Zip _____
 Person Responsible employed by _____ Occupation _____
 Business Address _____ Phone _____
 Insurance Company: _____ Contact number: _____
 Subscriber ID# _____ Group # _____
 Claims Address _____

SECONDARY INSURANCE

PHARMACY INFORMATION

Is the patient covered by another insurance? _____
 Subscriber Name _____
 DOB: _____ Phone _____
 Insurance company _____
 Contact # _____
 Claims Address _____

 ID# _____
 Group # _____

Which pharmacy do you use? _____
 Phone/Location _____
 Do you use a mail order company? Yes No
 Company Name _____
 Phone _____
 Fax _____
 ID Number _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above mentioned insurance company, and assign directly to Texas Family Physicians @ River Place all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.
 I authorize the use of my signature on all insurance submissions.
 Texas Family Physicians @ River Place may use my health care information and my disclose information to the above Insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end one year from the date signed below.

 Signature of Patient or Responsible Party _____
 Date Signed

 Please print name of Patient/Responsible Party _____
 Relationship to Patient