Houston Endocrine Center

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Patient Registration Form

Name _____ _____ _____
Last First Middle

Address _____ _____ ___ _____
Street City State Zip

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Home Phone _____ Work/Cell _____

Social Security # _____ - _____ - _____ Ref Physician: _____

Guarantor Information

Guarantor Name _____ _____ _____
Last First Middle

Address _____ _____ ___ _____
Street City State Zip

Guarantor Date of Birth _____ Sex ____ SS# _____ - _____ - _____

Relationship to Patient _____ Phone _____

Insurance Information

Primary Insurance _____

Policy # _____ Group # _____ Phone# _____

Secondary Insurance _____

Policy # _____ Group # _____ Phone# _____

Emergency Contact:

Name: _____ Phone: _____ Relationship _____

Name: _____ Phone: _____ Relationship _____

FOR ALL PATIENTS:
Assignments of insurance benefits and authorization for release of information:
(Please read carefully and sign below).

I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for the non-covered services. I also authorize the physician to release any information required to process all insurance claims.

Date: _____ Signature: _____