PATIENT REGISTRATION FORM

In order to serve you better, please ***complete*** all of the information below.
All information will be strictly confidential. **(Please print)**

Patients Name: _____ **Sex:** M F **Birth Date:** _____/_____/_____
Last **First** **MI**

Address: _____ **Marital Status:** Single [ ] Widowed [ ]
Street **City** **State** **Zip Code** Married [ ] Divorced [ ]

Phone #: (____) ____ - ____ (____) ____ - ____ (____) ____ - ____ **Patient's Social Security #:** ____ - ____ - ____
Home **Work** **Cell**

E-Mail Address: _____ **Occupation:** _____

Employer: _____ **Address:** _____ **Phone:** (____) ____ - ____

Race: American Indian/Alaska Native [ ] Asian [ ] Black/African-American [ ] Native Hawaiian/Other Pacific Island [ ]
White (Including Hispanic) [ ] Other Race [ ] Decline [ ]

Ethnicity: Hispanic or Latino [ ] Non-Hispanic or Non-Latino [ ] Other [ ] Decline [ ]

Preferred Language: English [ ] Spanish [ ] Other _____ Decline [ ]

Emergency Contact: _____ (____) ____ - ____ **Relationship to Patient:** _____
Name **Phone**

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: _____ **Relationship to Patient:** _____
Last **First**

Address (if different from patient): _____ **Birth Date:** ____/____/____

Phone #: (____) ____ - ____ (____) ____ - ____ **Responsible Party's Social Security #:** ____ - ____ - ____
Home **Cell**

INSURANCE COVERAGE

Primary Insurance: _____
Company Name **Address**

Subscriber's Name: _____ **Patient Relationship to Subscriber:** _____

Subscriber's Birth Date:___/___/____ **Policy #:**_____ **Group #:**_____ **Phone #:** (____) ____ - ____

Secondary Insurance: _____
Company Name **Address**

Subscriber's Name: _____ **Patient Relationship to Subscriber:** _____

Subscriber's Birth Date:___/___/____ **Policy #:**_____ **Group #:**_____ **Phone #:** (____) ____ - ____

Medicare Lifetime Signature on File (Medicare Patients Only)

I request that payment of authorized Medicare benefits be made on my behalf to Hill Country Medical Associates for any services furnished me by physicians of the group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ ____/____/____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Release of Information

I, the undersigned, authorize payment of medical benefits to Hill Country Medical Associates (HCMA) for any services furnished to me by the physicians of the group. I understand that I am financially responsible for any amount not covered by my contract. I also authorize HCMA to release, to my insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims benefits.

_____ ____/____/____
Patient, Parent, or Guardian Signature (if child is under 18 years old) Date