PATIENT REGISTRATION

FORT WORTH MEDICAL SPECIALISTS, 724 Pennsylvania Avenue Fort Worth, TX 76104 (817) 336-1200

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last)*_____

Date of Birth _____ Male / Female **Marital Status:** S M W D

Address _____

CITY_____ **State**_____ **Zip**_____

Home Number _____ **Cell Number** _____

Social Security # _____

EMAIL ADRESS:_____

Spouse/Partner name_____**BDAY**_____

Policy Card Holder Information

Name_____ **BDAY**_____

Relationship_____

Emergency Contact _____ **Relationship**_____

PHONE_____

Referring

Physician/person_____

CO-PAY DUE UPON VISIT:

I HAVE BEEN GIVEN THE OPPORTUNITY TO READ YOUR PRIVACY INFORMATION AND AUTHORIZE YOU TO DISCUSS MY MEDICAL INFORMATION WITH THOSE INDIVIDUALS LISTED ABOVE. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR THE CHARGES INCURRED AT THIS FACILITY AND PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. SHOULD I BE HOSPITALIZED I AUTHORIZE MEDICAL BENEFITS TO BE PAID DIRECTLY TO THIS FACILITY.

I hereby assign, transfer, and set over to Fort Worth Medical Specialists all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____