

Patient Information

As listed on your insurance

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: Male Female

If your *actual* name, DOB, or gender is different than your insurance records:
Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: Male Female

Mailing Address: _____ Apt/Suite #: _____
City: _____ State: _____ Zip Code: _____ - _____
Social Security Number: _____ - _____ - _____ Marital Status: _____
Driver License Number: _____ Issuing State: _____

e-mail address: _____ (for patient portal registration)

Home Phone: _____ *Cell Phone: _____
Work/Alternate Phone: _____ extension: _____

eMessenger Preferences

Circle One: Morning Afternoon Evening
Circle One: Home *Cell Work/Alternate
*If you prefer text messages, initial here _____.
*Standard text messaging rates apply

Spouse Information _____ N/A

Last Name: _____ First Name: _____ MI: _____
Primary Phone: _____ Alternate Phone: _____
Work Phone: _____ extension: _____
Date of Birth: _____ Sex: Male Female
Social Security Number: _____ - _____ - _____
Driver License Number: _____ Issuing State: _____

Acknowledgements, Authorizations and Assignment of Benefits

As a courtesy to our patients and at your request, we will be happy to file charges for your office visit with your Insurance Company. Please be aware that verification of benefits and filing of a claim DOES NOT GUARANTEE PAYMENT. The determination of whether the bill is paid is made by the Insurance Company when they receive the bill. I hereby authorize East Houston Medical Group to release to my Medical Insurance Company or its representatives any information requested by them including the diagnosis and the records of my treatment or examination performed on me. Furthermore, I authorize my Insurance Company to pay all medical benefits directly to East Houston Medical Group for services provided to me or my dependent(s). If for any reason my Insurance Company fails to make payment on my behalf within 120 days, I agree to pay the balance of my account in full without delay.

I hereby certify that I DO NOT have any other Medical Insurance Coverage other than: _____.

I hereby authorize East Houston Medical Group to treat my medical conditions.

I acknowledge that the HIPAA privacy notice has been made available to me and that a copy will be given to me upon my request.

I understand that I may be charged for missed appointments and other administrative fees.

Patient Signature: _____ Date: _____

Insurance Information

Primary Carrier

Company Name: _____ Phone: _____

ID Number: _____ Group Number: _____

Main Insured: Self Spouse *Other

*if you choose Other, please fill in Main Insured Information below

Secondary Carrier

Company Name: _____ Phone: _____

ID Number: _____ Group Number: _____

Main Insured: Self Spouse *Other

*if you choose Other, please fill in Main Insured Information below

Main Insured Information

Last Name: _____ First Name: _____ MI: _____

Relationship to patient: _____ Date of Birth: _____ Sex: Male Female

Social Security Number: _____ - _____ - _____

Medicare Part D Drug Program (if different than medical insurance company)

Company Name: _____ Phone: _____

Preferred Pharmacy

Local Pharmacy Name: _____ Mail Order Pharmacy: _____

Address or Location: _____ Address or Location: _____

City, State, Zip: _____ City, State, Zip: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Pharmacy Member ID: _____

May we communicate electronically with pharmacies regarding your past and current prescription records? Circle One: Yes No

Patient Signature: _____ Date: _____

Do you have an Advance Directive, power of attorney, medical power of attorney and/or do not necessitate order?

_____ Yes (please provide us with a copy for our records)

_____ No, but I would like more information about this.

_____ No, and I do not want information about this.

Government regulations require us to document how patients identify their own **race and ethnicity**.

Please select one choice from each list.

Race:

American Indian or Alaska Native _____

Asian _____

Native Hawaiian or Other Pacific Islander _____

Black or African American _____

White _____

Hispanic _____

Other Race _____

Other Pacific Islander _____

Unreported/Refused to Report _____

Ethnicity:

Hispanic or Latino _____

Non-hispanic or Latino _____

Refused to Report _____

Please tell us how you heard about us:

_____ Internet

_____ Newspaper

_____ Employer, Please specify _____

_____ Friend / Family Member, Please specify _____

_____ Drove by / saw the sign

_____ Other

Patient Signature: _____ **Date:** _____

Emergency Contact

This person will only be contacted if we are unable to contact you regarding an urgent matter, or if you have a medical emergency while in our office.

Last Name: _____ First Name: _____

Relationship to Patient: _____

Street Address: _____ Apt/Suite #: _____

City: _____ State: _____ Zip Code: _____ - _____

Primary Phone: _____ Alternate Phone: _____

Work Phone: _____ extension: _____

I authorize East Houston Medical Group to discuss my personal health information including appointments, diagnosis, plan of treatment, medication, referrals, and billing with the following individuals:

_____ Initial here if we are allowed to discuss this information with your emergency contact

Last Name: _____ First Name: _____

Relationship to Patient: _____

Primary Phone: _____ Alternate Phone: _____

Last Name: _____ First Name: _____

Relationship to Patient: _____

Primary Phone: _____ Alternate Phone: _____

Last Name: _____ First Name: _____

Relationship to Patient: _____

Primary Phone: _____ Alternate Phone: _____

---OR---

_____ Initial here if we should speak only to you about your personal health information.

Patient Signature: _____ Date: _____