EAST HOUSTON MEDICAL GROUP
Registration Form (Adults)
Please read carefully and fill out all applicable fields.

Thank you for choosing us as your health care provider!
The front desk needs your photo ID and insurance card.
We would like to get a photo of you before you leave today.

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: _____

Address or Location: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Mail Order Pharmacy: _____

Address or Location: _____

City, State, Zip: _____

Phone: _____

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 recessitate 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:** _____