Patient Registration Form

First Name_____ **Middle**_____ **Last**_____

Address _____

City _____ **State** _____ **Zip** _____

Date of Birth _____ **Age** _____ **Sex** _____ **SS#** _____

Phone # (_____) _____-_____ **Cell #** (_____) _____-_____

Email _____

Emergency Contact Name/# _____

Preferred Method of contact: Circle One: Email Letter Telephone

Race: White/Black/Hispanic/ American Indian/Alaska Native/ Asian/Pacific Islander
Ethnicity (Circle One): Hispanic / Non-Hispanic
Veteran: (Circle One): Yes No

Single _____ Married _____ Partnered _____ Widowed _____ Divorced _____

Preferred Language _____

Employed by _____
Work # _____ Ext _____

Name of Spouse/Partner _____
Date of birth _____ SS# _____
Employed by _____
Work # _____ Cell # _____

Medicare or Medicaid # _____
OR
Primary Insurance _____
Insured's Name _____
Insured's Date of Birth _____ SS# _____
Policy# _____ Group # _____

Secondary Insurance _____
Insured's Name _____
Insured's Date of Birth _____ SS# _____
Policy# _____ Group # _____

Preferred Pharmacy _____

Assignment of Benefits:
I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and any other plan to Brown Family Health, Health Horizons of East Texas, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and to request a review of claim.

Signed: _____ **Date:** _____