TexomaCare: Patient Registration / Informacion Sobre El/La Paciente

PATIENT INFORMATION / INFORMACION PACIENTE

Patient: Last, first name and middle initial / Garantizador: Apellido, Nombre			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono email: _____
Physical Address / Direccion: Numero Calle Cuidad Estado Zono Postal			
Mailing Address, if different from Physical Address / Otro Direccion			
Employer / Patron De Garantizador			Employer's Telephone # Numero de Telefono del Patron de Garantizador

FINANCIAL INFORMATION, Part I / INFORMACION DEL PACIENTE I

***Responsible party if other than patient**: Last, first name and middle initial / Paciente: Apellido, Nombre *this person would be responsible and receive the bills after insurance responded			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono
Mailing Address, if different from Patient / Direccion: si es Differente de el Garantizador			Relationship to Guarantor Relacion at Garantizador

RELEASE OF INFORMATION-PLEASE LIST ALL PERSONS AUTHORIZED TO OBTAIN MEDICAL/FINANCIAL INFO

Last, first name and middle initial / Apellido, Nombre	Relationship:
Last, first name and middle initial / Apellido, Nombre	Relationship:
Last, first name and middle initial / Apellido, Nombre	Relationship:
Last, first name and middle initial / Apellido, Nombre	Relationship:

PATIENT INFORMATION, Part II (if applicable)/ INFORMACION SOBRE EL PACIENTE (si es aplicable)

Patient's Employer / Patron de Paciente	

EMERGENCY CONTACT / EN CASO DE EMERGENCIA

Emergency Contact / En caso de Emergencia Llama	Emergency Contact's Telephone # / Numero de Telefono

Referring Physician:

Family Physician:

Pharmacy preference: **CITY:**

Do you want to be Web Enabled?: ❑ **Yes** ❑ **No** **email address:**

TEXOMACARE

INSURANCE INFORMATION / INFORMACION SOBRE ASEGURANCIA

Primary Insurance **Nombre de la Compania de Asegurancia Primario**	ID or Policy # / Numero de Poliza	Phone # / El teléfono #	Group # / Numero de Grupo
Subscriber's Name (who owns the policy) Nombre de Suscriptor	Date of Birth Fecha de Nacimiento	Employer / Patron de Suscriptor	Effective Date Fecha de Valido
Secondary Insurance **Nombre de la Compania de Asegurancia Secundario**	ID or Policy # / Numero de Poliza	Phone # / El teléfono #	Group # / Numero de Grupo
Subscriber's Name (who owns the policy) Nombre de Suscriptor	Date of Birth Fecha de Nacimiento	Employer / Patron de Suscriptor	Effective Date Fecha de Valido

CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY
MEDICAL PERMISCO para TRATAMIENTO y RESPONSIBLE de PAGOS

The patient agrees to general medical treatment by TexomaCare physicians and understands and consents to the review and use of his/her medical records by any TexomaCare physician. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to that the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.
Deside usted que le van a dar tratamiento medico general, por los doctores de TexomaCare y consultar con ostros doctores de TexomaCare. Todos los servicias son la responsabilidad de usted. Lienamos las formas para cobrar a su asegurancia, pero usted es responsable por los cobros. Es costumbre pagar por servicios el mismo dia o tal vez si a hecho otros arregralmentos antes de la cita.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS
PERMISO para ASEGURANCIA y BENIFICCIOS

I hereby authorize TexomaCare to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any TexomaCare physician. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked in writing by me.

➔**Signature of patient / legal representative:**

HIPAA – NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and/or spouse/children may be used and disclosed and how you can get access to this information. I acknowledge that the TexomaCare Notice of Privacy Practices has been provided.

➔**Signature of patient / legal representative**:

PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR

The authorization form is to give consent to someone(s) other than a parent/legal guardian for the medical treatment of the patient for any unhealthy condition or well visits.

➔**Signature of Parent , Patient or Head of Household** / Garantizador: Apelido, Nombre	**Date** / Fecha de Firma

OFFICE USE

Data Collected by Whom:	Date of Data Collection:	Data Entered by Whom	Date of Data Entered:

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PATIENT INFORMATION