PREVENTATIVE CARE INSTITUTE

Registration Form	PCP:

PATIENT INFORMATION

Patient's last name:	First Name	Middle

Birth date:		Social Security No:	Age:	Sex	Marital status:
					Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Street address:	City/State	Zip Code

Cell No:	Home No:		
OUT STATE ADDRESS:	City:	State:	Zip Code:

EMPLOYER NAME	
PHONE #	
IN CASE OF EMERGENCY	Name of local friend or relative (not living at same address):
Name:	PHONE#

☐ Private Ins. ☐ Medicare ☐ Medicaid ☐ Private Pay ☐ Workers Comp.

INSURANCE INFORMATION	☐ Is this a primary insurance	
Insurance Name:	ID#	Relationship:
Name of insured person:	DOB:	SSN#

2ND INSURANCE INFORMATION	☐ Is this a secondary insurance	
Insurance Name:	ID#	Relationship:
Name of insured person:	DOB:	SSN#

Assignment of Benefits / Treatment & Patient Agreement

The above information is true to the best of my knowledge. I understand payment for services are due when services are rendered. I understand that I am financially responsible for any copays /deductibles or portions not covered by my insurance. I authorize my insurance benefits be paid directly to the physician. I also give Preventative Care Inst. and Physicians my consent for treatment. I understand that this treatment consent applies to this visit , all future visits , and all radiological services.

Please be advised that services performed may incur **other third party charge**s such as: radiologist reading, laboratory, physical therapy, and electrocardiography reading, etc.

Acknowledgment of Notice of Privacy Practice

I have been presented with a copy of the Notice of Privacy Practices for the office of RGV Preventative Care Institute, detailing how my information may be used and disclosed as permitted under federal and state law. I have read the about acknowledgement and agreements, and fully understand the same.

_____ _____

Patient, Parent or Guardian Signature Date

_____ _____

PRINT Patient, Parent or Guardian Name Relationship to patient

_____ _____

Witness Date

********** FOR OFFICE USE ONLY **********

_____ _____

Office staff signature date