

LONE STAR FAMILY HEALTH CENTER

PATIENT REGISTRATION INFORMATION

Please complete in full

Date

Patient Information				
Last Name		First Name	Middle Name	Date of Birth
Age	Race & Country of Origin	Sex [] Male [] Female	Civil Status [] Single [] Married [] Divorced [] Widowed	
Name of Person Legally Responsible (if minor)				
Home Address (Include Apt. No.)				
City	State	Zip Code	Home Phone	
Social Security No.	Driver's License No.	Annual Income (must supply for Sliding Fee Scale and Medicaid patients)	Cellular Phone	
Employer			Business Phone	
Employer's Address				
Nearest relative not living with you		Relationship	Phone No.	
Relative's Address (house no., street, apt. no., city, state, zip)				
Patient's Spouse/ Parent Information				
Last Name		First Name	Middle Name	Date of Birth
Age	Social Security No.	Driver's License No.	Occupation	
Employer				
Employer's Address				
Financial Responsibility				
Person Responsible for this Account			Relationship to Patient	
Social Security No.	Date of Birth	Annual Household Income	No. of People in Household	
Medicare No.		Medicaid No.		
Insurance Company		Policy No.	Group No.	
Insurance Company's Address				
Referral				
Referred by		Address		
Authorizations				
I hereby authorize Lone Star Family Health Center to furnish information to Insurance Carriers concerning this illness/accident. Patient's signature X				
I hereby irrevocably assign to Lone Star Family Health Center all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by Insurance. Patient's signature X				
I hereby give consent for treatment of my medical problems to the health care providers of the Lone Star Family Health Center. Patient's signature X				