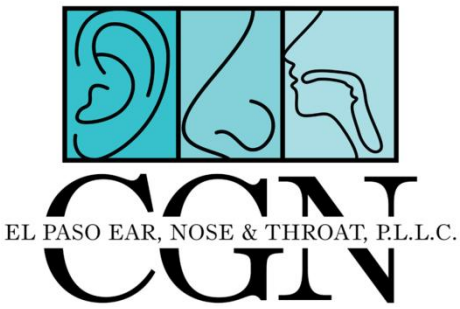

5959 Gateway West Ste. 160 El Paso Texas 79925
(915)779-5866

PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name: _____
Middle Initial: _____
Last Name: _____
Gender: _____
Date Of Birth: _____
Social Security Number: _____
Status: Single Married Other: _____

DEMOGRAPHICS

Address: _____
City: _____
State: _____
Zip Code: _____
Telephone Number: _____
Email Address: _____

RESPONSIBLE PARTY

Name: _____
Address: _____
Date of Birth: _____
Social Security Number: _____
Telephone Number: _____

Relationship To Patient: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder Name: _____

Policy Type: HMO PPO Other: _____

Policy ID: _____

Group Number: _____

Relation to Patient: _____

Subscriber Date Of Birth: _____

Subscriber Social Security: _____

SECONDARY INSURANCE

Insurance Name: _____

Policy Type: HMO PPO Other: _____

Policy ID: _____

Group Number: _____

Subscriber Name: _____

Subscriber Date Of Birth: _____

Subscriber Social Security: _____

REFERING PHYSICAN: _____

NEW INSURANCE POLICY:

If you have a new insurance, please provide the new information along with new insurance card(s). It is very important you keep us updated with your correct insurance information. If we do not have the correct insurance information a balance will incur and you will be billed as self-pay.

Signature:_____

Date:_____