PATIENT REGISTRATION

Today's Date: _____

Last Name:_____ First Name:_____MI:_____

Mailing Address: _____

City: _____ State: ❑ Texas Other:_____ Zip Code:_____

Home Phone: _____Cell Phone: _____

Age: _____ Date of Birth: _____Sex: ❑ Female ❑ Male

Social Security Number: _____

Marital Status: ❑Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other: _____

Spouse's Name: _____

Consent to send statements and appointment reminders by email: ❑ Yes ❑ No

E-mail address: _____

Preferred Pharmacy: _____Location: _____

Do you have a physician? ❑ Yes ❑ No If yes, Physician's Name:_____

EMPLOYMENT INFORMATION

Employment Status: ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Retired ❑ Self-employed ❑ Student

Employer: _____

Address:_____

City: _____State: ❑ Texas Other: _____ Zip Code: _____

Work Phone: _____ Extension: _____

Guarantor or Card Holder Information:

Last Name: _____First Name: _____ MI: _____

Relationship to patient:_____

Social Security Number:_____

Date of Birth:_____

Cell Phone:_____

Mailing Address if different from above: _____

City:_____ State: ❑ Texas Other:_____ Zip Code: _____

PAYMENT INFORMATION

Do you have Insurance? ❑ Yes ❑ No Are you a self-pay patient? ❑ Yes ❑ No

How did you locate us or get our phone number: ❑ Phonebook ❑ Internet ❑ Other: _____

Person to notify in case of emergency: _____

Relationship:_____Phone Number:_____❑ Cell ❑ Home ❑ Other

Brazosport Regional
FAMILY MEDICINE CENTER