Lone Star Physicians Group, P.A.

NEW PATIENT REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	Preferred Name	Date of Birth: / /
				Sex: Male Female
Street address:		Apt. #		SS. No: - -
P.O. Box:	City:		State:	ZIP:
Home phone:				
Mother (Legal Guardian) Name:			Occupation:	
Address (if different from above):				
Cell phone:	Work phone:		E mail:	
Father (Legal Guardian) Name:			Occupation:	
Address (if different from above):				
Cell phone:	Work phone:		E mail:	
Referred by: Insurance Family Friend		Yellow pages	Physician	Other
Other family members seen here:				

INSURANCE INFORMATION

(Please give the insurance card and driver's license to the receptionist.)

Person responsible for bill:			Home phone no.: ( )		
Address (if different):					
Birth date: / /	S.S. No.: / /		Occupation:		
Employer:				Employer phone no.:	
Employer address:				( )	
Is this patient covered by insurance? ❑ Yes ❑ No		❑ Primary Insurance			
Subscriber's name: (if different from above)	Subscriber's S.S. No.:	Birth date:	Subscriber ID/Policy #	Group #	Co Pay
	/ /	/ /			$
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Secondary insurance: □ Yes □ No					
Subscriber's name: (if different from above)	Subscriber's S.S. No.:	Birth date	Subscriber ID/Policy #	Group #	Co Pay
	/ /	/ /			$
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lone Star Physicians Group, P.A or insurance company to release any information required to process my claims.

Preferred E-mail address (for our office communications only):	
Parent/Guardian signature:	*Date:*
Parent/ Guardian Name (Print):	