REGISTRATION

Touchstone Internal Medicine & Pediatrics

Patient Information *(Please Print)*

Name_____ SSN_____
Last Name First Name Initial

Address_____City_____ State_____ Zip_____

Age _____ DOB#_____ Home# _____ Cell#_____ Texas Driver's License#_____

PLEASE CIRCLE:

GENDER: Male / Female MARITAL STATUS: Single / Married / Widowed / Separated / Divorced

RACE: African American / Arabic / Asian / Hispanic / Vietnamese / Caucasian / Other:_____

LANGUAGE: Arabic / English / Indian / Russian / Spanish / Vietnamese / Other:_____

Patient Employed by _____ Occupation _____

Business Address _____ City_____ State_____ Zip _____

Business Phone_____ Email Address_____

In case of emergency who should be notified?_____ Relationship to patient_____ Phone #_____

Pharmacy: _____ Address/Zip _____Phone #_____

Primary Insurance *(Please Print)*

Person Responsible for Account_____
Last Name First Name Initial

Relationship to Patient_____ DOB:_____ SSN:_____

Address (if different from patient) _____ City_____ State_____ Zip_____

Person Responsible Employed by _____ Occupation_____ Texas Driver's License #_____

Business Address _____ City_____ State_____ Zip_____

Business Phone #_____ Names of dependents covered under this plan_____

Insurance Company_____ Subscriber ID#_____ Group #_____

Additional Insurance *(Please Print)*

Is patient covered by additional insurance? Yes or No Subscribers Name:_____
Last Name First Name

Address (if different from patient)_____ City_____ State_____ Zip_____

DOB_____ Relationship to Patient_____ Texas Driver's License #_____

Subscribers Phone #_____ Subscriber Employer_____ Occupation_____

Employers Address_____ City_____ State_____ Zip_____

Insurance Company_____ SSN#_____

Subscriber ID#_____ Group #_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with (List all Insurance Companies) _____
_____, and assign directly to Touchstone Internal Medicine & Pediatrics all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____ Relationship:_____ Date:_____