DFW RHEUMATOLOGY

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Patient Registration Form

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____ Social Security Number: _____
Gender: _____ Sex: _____ Marital Status: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Mobile Phone: _____ Home Phone: _____
Email: _____ Preferred Language: _____
Employment Status: _____Employer Name: _____
Race: ☐ White ☐Black/African American ☐Asian ☐American Indian ☐Hawaiian ☐Declined to Specify
Ethnicity: ☐ Hispanic/Latino ☐Unknown ☐ Non-Hispanic/Latino ☐Declined to Specify
Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____

Primary Insurance:
Policy Holder Name: _____ Date of Birth: _____
Social Security Number: _____ Relationship to Patient: _____
Insurance Carrier Name: _____ Policy Type: _____
Subscriber ID Number: _____ Group ID Number: _____

Secondary Insurance:
Policy Holder Name: _____ Date of Birth: _____
Social Security Number: _____ Relationship to Patient: _____
Insurance Carrier Name: _____ Policy Type: _____
Subscriber ID Number: _____ Group ID Number: _____

Emergency Contact Information:
Name: _____ Relationship to Patient: _____
Phone: _____

I hereby consent to the treatment as prescribed by my physician and provided by DFW Rheumatology, its employees, or representative. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage.I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill. I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to DFW Rheumatology for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by DFW Rheumatology. Further, I authorize DFW Rheumatology to obtain needed information from my physician, employer or insurance company.

_____ _____
Signature of Patient Date