

HEALTHCARE ASSOCIATES OF IRVING PATIENT REGISTRATION FORM

*This form must be completed before seeing the Doctor to insure accurate records for your medical file and to secure payment from your insurance company. **Payment must be made at time of service.***

Chart Number:		Fax: 972-659-9807	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
Social Security no.:		Marital status (circle one) Single / Married / Divorced / Separated / Widowed	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Age:	Birth date: / /	
Home phone no.: ()		Cellular phone no.: ()	
Mailing address:			
City, State:			ZIP Code:
Street address:			
City, State:			ZIP Code:
E-mail Address:			
Employer (Company Name):			Employer Phone:
<u>Referring Doctor Name:</u>			
Referring Address:			Referring Dr. Phone:
INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)			
Name of Family Members on Insurance Policy:			
Primary Insurance Co. Name:			<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> EPO
Secondary Insurance Co. Name:			<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> EPO
<u>INSURANCE POLICY HOLDER (RESPONSIBLE PARTY) INFORMATION</u>			
Last Name:		First:	Middle:
Social Security no.:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birth date: / /
Employer (Company Name):		Employer Phone:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other

*I authorize the release of my medical information necessary to process this claim for payment of insurance benefits to HAI.
I understand I am responsible for all charges insurance does not pay including non-covered procedures.*

Patient / Responsible Party Signature: _____ Date: _____