REGISTRATION

CAMPBELL FAMILY PRACTICE
INTERNAL MEDICINE ASSOCIATES

10950 Resource Parkway, Suite A
Houston Texas 77089
281-484-5587

(Please Print)

PATIENT INFORMATION

Name:_____ Social Security #:_____
Last Name First Name Initial

Address:_____ City_____ State_____ Zip_____

Age_____ Date of Birth_____ 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: Name_____ Address/Zip_____ Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Initial

Relationship to Patient_____ Date of Birth _____ Social Security #_____

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

Is patient covered by additional insurance? Yes or No Subscribers Name_____
Last First

Address (if different from patient)_____ City_____ State_____ Zip_____

Date of Birth _____ Relationship to Patient_____ Texas Driver's License #_____

Subscribers Phone #_____ Subscriber Employer_____ Occupation_____

Employers Address_____ City_____ State_____ Zip_____

Insurance Company_____ Social Security #_____

Subscriber ID# _____ Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____
Name of Insurance Company(ies)

And assign directly to Campbell Family Practice 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:_____