

FAMILY
HEALTHCARE
Stanley C. Evans, D.O.

Chart # _____

Patient Registration

E-mail: Familyhealthcareofdenton@hotmail.com

Fax: 940-383-2224

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.**

Patient Information

Name: _____ Social Security No: _____ - _____ - _____

Date of Birth: _____ / _____ / _____ Age: _____ Sex: M / F Marital Status: S D M W Sep

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ (____) _____ (____) _____
Home Business Cell

Employer (Company Name): _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Family Members: _____ D.O.B.: _____

_____ D.O.B.: _____

_____ D.O.B.: _____

Insurance Information

Insurance Co.: _____ Member Service Phone: (____) _____

PPO POS HMO Commercial Other ID: _____ Group: _____

Insurance Policy Holder (Responsible Party) Information

Name: _____ Social Security No: _____ - _____ - _____

Relationship to Patient _____
Last First M.I.

Employer (Company Name): _____ Phone: (____) _____

Business Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Insurance Co.: _____ Member Service Phone: (____) _____

PPO POS HMO Commercial Other ID: _____ Group: _____

Secondary Insurance Policy Holder Information

Name: _____ Social Security No: _____ - _____ - _____

Relationship to Patient _____
Last First M.I.

Employer (Company Name): _____ Phone: (____) _____

Business Address: _____ City: _____ State: _____ Zip: _____

I authorize the release of my medical information necessary to process this claim for payment of insurance benefits to Family Healthcare and to obtain the proper information for referral forms. I also authorize the office to obtain insurance information from Medicare regarding any claims submitted on my behalf. I understand I am responsible for all charges that insurance does not pay including non-covered procedures.

Patient/Responsible Party Signature _____ Date: _____