FAMILY
HEALTHCARE
Stanley C. Evans, D.O.

Chart #_____

Patient Registration

E-mail: Familyhealthcareofdenton@hotmail.com
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 e made at time of service.

Patient Information

Name: _____ Social Security No: _____- _____ - _____
Last First M.I.
Date of Birth: ___/___/___ Age: _____ Sex: M/F Marital Status: S D M W Sep
Address: _____ City: _____ State: ____ Zip: _____
Phone: (___)_____ Phone: (___)_____ 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: _____- _____ - _____
Last First M.I.
Relationship to Patient_____
Employer (Company Name): _____ Phone: (___)_____
Business Address: _____City: _____State: _____ Zip: _____

Secondary Insurance

Name: _____ Social Security No: _____- _____ - _____
Last First M.I.
Relationship to Patient_____
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 changes that insurance does not pay including non-covered procedures.

Patient/Responsible Party Signature _____Date:_____