RHEUMATOLOGY ASSOCIATES of SOUTH TEXAS

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(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Preferred Language: Eng ___ Span____ Other____	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no: ( )

P.O.Box:	City:	State/Zip:	Cell phone :

Ethnicity:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ Medicare	☐ Humana HMO ☐ Humana PPO	☐ Aetna HMO ☐ POS ☐Aetna PPO	☐ Secure Horizons	☐ United Health Care
☐ PHCS	☐ Medicaid	☐ Cigna HMO ☐ POS ☐ Cigna PPO	☐ Texas True Choice	☐ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_______________________________ _______________

Patient/Guardian signature *Date*