



RHEUMATOLOGY ASSOCIATES of SOUTH TEXAS

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Today's date:		PCP:					
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Preferred Language: Eng ___ Span ___ Other ___		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:	Employer phone no.:				
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> Humana HMO <input type="checkbox"/> Humana PPO	<input type="checkbox"/> Aetna HMO <input type="checkbox"/> Aetna PPO	<input type="checkbox"/> POS	<input type="checkbox"/> Secure Horizons	<input type="checkbox"/> United Health Care
<input type="checkbox"/> PHCS	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Cigna HMO <input type="checkbox"/> Cigna PPO	<input type="checkbox"/> POS	<input type="checkbox"/> Texas True Choice		<input type="checkbox"/> Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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	