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

Email Address:	Race:	Ethnicity:
Street address:	Social Security Number:	Home Phone Number: ( )

City:	State:	Zip:	Cell phone ( )
Employer:	Employer phone number: ( )		
Referred to clinic by/Chose clinic because (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other
Other family members seen here:			
Pharmacy Name:	Pharmacy Phone Number:		

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*

Revised Sept. 2016