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PATIENT YEARLY REGISTRATION FORM | Today's Date:

PATIENT INFORMATION

Patient's **Last name**:	**First**:	**Middle**:	**Marital status**: (circle one) Single / Mar / Div / Sep / Wid

Race and Ethnicity	Preferred Contact # Circle One Home Cell Work	**Birth date**: / /	**Age**:	**Sex**: [ ] M [ ] F

Mailing **address**:	**Social Security #:**	Home **phone**: ( )
City: **State**:	**ZIP** Code:	Cell or Work **phone**: ( )

Referred to clinic by (please check one box): [ ] Stonebridge directory
[ ] Family [ ] Friend [ ] Close to home/work [ ] Yellow Pages [ ] McKinney Magazine
[ ] Other [ ] Insurance Plan [ ] Welcome Wagon [] Dr. _____

Family members seen by Dr Brinkman, George or DeShazo:
_____
_____

PAYMENT & INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill: (if different than patient)	Birth date: / /	Is this person a patient here? [ ] Yes [ ] No Is this person insured? [ ] Yes [ ] No

Mailing address: (if different than patient)	Social Security #:	Home phone: ( )
City: State:	ZIP Code:	Cell or Work phone: ( )

Primary Insurance:	Group #:	Policy no.:	Co-payment:	Effective Dates: / / to / /

Subscriber's Name: (if different than patient)	Subscriber's S.S. #:	Subscriber's Birth Date / /

Patient's relationship to subscriber: [] Self [] Spouse [] Child [] Other

Secondary Insurance: (if applicable)	Group #:	Policy no.:	Co-payment:	Effective Dates: / / to / /

Subscriber's Name: (if different than patient)	Subscriber's S.S. #:	Subscriber's Birth Date / /

Patient's relationship to subscriber: [] Self [] Spouse [] Child [] Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Home phone: ( )
Relationship to Patient:	Cell phone: ( )

The above 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 authorize Jeffrey A. George, M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ ***Date:*** _____