Conroe Family Medicine, P.A

690 S. Loop 336 W Ste 222
Conroe, TX 77304

Patient Registration Form

Patient's name: ________________________________ **Birth date:** ____________ **Sex: M F**
Address: ____ **Apt**______
City: ____________________________ **State:** _____ **Zip:** _________
Daytime Number:___________________________ **Cell Number:** _________________________
Can we leave a detailed message? Yes No **if so, what number:** __________________________
Social Security #:___________________________ **Driver's License:** ____________________
Email address: ______________________________________

Primary Insurance: ___________________________
Policy holder name: __________________________ **Policy holder DOB:** ________________
Policy holder ssn #: __________________________ **Relationship to patient:**_____________
Policy holder driver's license: __________________
Policy holder Employer's name: _____________________________

Dependents on this plan: ____
____

If patient is a minor, who is accompanying the child today? __________________________
Who is responsible for the account? _____________________________________
Address (if different from above): ____ **Apt:**_____
City: ______________________ **State:** _________ **Zip:** ___________ **Ph#** _______________

Emergency contact: ___________________________________
Relationship: _______________________ **Phone number:** ___________________________

What pharmacy do you use: ____
Phone number/Address:____

We ask that all patients show their insurance cards and allow us to make a copy for our records.

I herby authorize Conroe Family Medicine to furnish information to insurance carriers concerning my illness and treatments. I understand that I am responsible for any amount not covered by insurance. By signing I give consent to be treated by the physician at Conroe Family Medicine. It is the patient's responsibility to know their benefits and make sure specialist you are referred to accepts your insurance plan

Signature: ____ **Date:**______________