Family Care Clinic

Making families whole...inside and out.

WELCOME!

Patient Registration

Please Print

Patient Information

Patient's Full **Legal** Name: _____ SS#_____

DOB: _____/_____/_____ Age:_____ Sex: **M F** Marital Status.: **S M D W** Race _____

Mailing Address: _____ City:_____ Zip_____ County_____

Complete **Residentia**l Address (if different): _____

Cell phone: _____ home Phone: _____

EMAIL _____

Employer: _____ **Occupation**: _____

Employment Phone: _____ Ext: _____ Dept: _____

In case of emergency, please notify: _____ Phone:_____
Relationship to patient: _____

Fill out this section if patient is NOT the insurance Policy Holder. (GUARANTOR'S information)
Name of Insured: _____ Insured's DOB: _____
Insured's SS#_____ Insured's Phone: _____
Insured's Address: _____ City: _____State____ Zip:_____ County _____
Insured's Employer: _____ Occupation: _____work phone _____
Name of Insurance: _____ Insurance Phone: _____
Insured's ID #_____ Group #_____
Relationship to the Guarantor: **SPOUSE CHILD STEPCHILD GRANDCHILD OTHER**

How did you hear about the Family Care Clinic? [ ] Friend (Name) _____
[ ] Newspaper [ ] Physician (Name) _____ [ ] Yellow Pages Ad
[ ] School Teacher Referral (for ADD) [ ] Ennis Now Magazine [ ] Corsicana Now Magazine
[ ] Waxahachie Now Magazine [ ] Attended a lecture by Dr. Laws

---

Patient's Responsible Party

This section must be filled out if the patient is a minor AND the patient's responsible party is not the insured.

Name: _____
Complete Mailing Address: _____ City: _____
Zip: _____ Home Phone: _____ Other Phone: _____

Responsible Party Agreement

Method of Payment: Cash _____ Credit Card_____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF INSURANCE COVERAGE.

X SIGNATURE: _____ DATE: _____