3270 Joe Battle, Suite #360
El Paso, TX 79938

Phone: 915.351.9000
Fax: 915.351.9041

PATIENT REGISTRATION

NAME: _____ **DOB:** _____ **AGE:** ____ **M / F** MARITAL STATUS **S M W D SEP**

RACE **B H W OTHER**

ADDRESS: _____ **CITY/STATE/ZIP:** _____

PHONE: (HM) _____ **(WK)** _____ **(CELL)** _____

SSN #: _____ **OCCUPATION/EMPLOYER:** _____

SPOUSE/GUARDIAN NAME: _____ **DOB:** _____ **PHONE:** _____

SSN #: _____ **EMPLOYER:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____
(OTHER THAN SPOUSE) (NAME) (ADDRESS) (RELATIONSHIP)

REFERRED BY: _____ **PHARMACY:** _____
(PLEASE SPECIFY WHICH LOCATION)

IF UNDER 18 (PARENT/GUARDIAN): _____ **EMAIL ADDRESS:** _____

CHIEF COMPLAINT: _____

INSURANCE & BILLING INFORMATION

MEDICARE #: _____ **MEDICAID #:** _____

BILLING NAME: _____ **RELATIONSHIP:** _____
(IF OTHER THAN PATIENT)

BILLING ADDRESS: _____ **PHONE:** _____
(IF DIFFERENT FROM ABOVE)

PRIMARY INSURANCE: _____

NAME OF INSURED: _____ **RELATIONSHIP:** _____
ID #: _____ **GROUP #:** _____

SECONDARY INSURANCE: _____

NAME OF INSURED: _____ **RELATIONSHIP:** _____
ID #: _____ **GROUP #:** _____

Do you have an Advanced Directive? Y / N **LIVING WILL**

PATIENT / GUARDIAN SIGNATURE: _____ **DATE:** _____

PAYMENT IS REQUIRED AT TIME OF SERVICE