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Denton, TX. 76210
Phone: 940-205-6584
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Website: www.ConnectionsPrimaryCare.com

Patient Registration Form

PATIENT INFORMATION				
Name: LAST	FIRST	M.I.		**Gender** Male ☐ Female ☐
Date of Birth / /	**Primary Care Physician (PCP):**			
Address:	**City**:	**State**:	**Zip Code**:	
Home Phone ( ) -	**Alternate Phone** ( ) -			
PRIMARY INSURANCE & SUBSCRIBER INFORMATION				
Primary Insurance Name:	**Relationship to Subscriber:**			
Subscriber's Name: LAST	FIRST	M.I.	**Subscriber's Date of Birth** / /	
Subscriber ID #	**Group #**	**Plan #**	**Pharmacy #**	
SECONDARY INSURANCE				
Secondary Insurance Name:	**Relationship to Subscriber:**			
Subscriber's Name: LAST	FIRST	M.I.	**Subscriber's Date of Birth** / /	
Subscriber ID #	**Group #**	**Plan #**	**Pharmacy #**	
TERTIARY INSURANCE				
Tertiary Insurance Name:	**Relationship to Subscriber:**			
Subscriber's Name: LAST	FIRST	M.I.	**Subscriber's Date of Birth** / /	
Subscriber ID #	**Group #**	**Plan #**	**Pharmacy #**	
*If patient is a child, who may authorize treatment for this child?	*Relationship to Patient:	Phone No.: ( ) -		
Do you have a telephone answering machine or voicemail in your home?		Yes ☐	No ☐	
If so, may we leave messages from this office on that machine?		Yes ☐	No ☐	
Do you authorize release of your medical information to anyone besides your insurance carrier(s)?		Yes ☐	No ☐	
If so, whom?				

I authorize Connections Primary Care to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Connections Primary Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize Connections Primary Care to release all information necessary to secure payment and treatment.

_____ _____

Patient, Parent / Guardian's Signature Date

_____

Printed Name of Signee