F.W. Huston Medical Center

(Please Print)

Today's Date:	**Primary Physician:**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	City, State:	ZIP Code:

Home Phone:	Cell Phone:	Work Phone:	OK to leave phone message on: ☐ Cell ☐ Home ☐ Work
Social Security #:	Employer:		Occupation:

Email address:	Education - highest level achieved:

If patient <18 yrs old:	Lives with: ☐ Mother ☐ Father ☐ Guardian	Mother: Phone:	☐ Father ☐ Guardian: Phone:

Person responsible for bill: (If not as above)	Address:	Home Phone: Cell Phone:

INSURANCE INFORMATION ****PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST****

Primary insurance:	**Secondary Insurance:**
☐ Medicare ☐ Medicaid ☐ BCBS ☐ Aetna ☐ UHC ☐ Cigna ☐ Coventry ☐ Tricare ☐ Work/Comp ☐ Other:	☐ Medicare ☐ Medicaid ☐ BCBS ☐ Aetna ☐ UHC ☐ Cigna ☐ Coventry ☐ Tricare ☐ Work/Comp ☐ Other:
Policy Holder's name:	Policy Holder's name:
Group #: / Policy #:	Group #: / Policy #:
Date of Birth: / Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other:	Date of Birth: / Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other:
Address (if different from above):	Address (if different from above):
Home phone: / Cell phone: / Work phone:	Home phone: / Cell phone: / Work phone:
Employer:	Employer:

Optional: *(for statistical purposes)*

Patient's Race:	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other:	Preferred Language: ☐ English ☐ Other:

IN CASE OF EMERGENCY

Name of Emergency contact:	Relationship to patient:	Home phone #:	Cell phone #:

The above information 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 also authorize JCMH/FWH or insurance company to release any information required to process my claims. I am also financially responsible to JCMH/FWH for charges and/or collection fees incurred if my account is referred to an outside agency or attorney for collections.

Patient/Parent Signature *Date*