



Texas Family Medicine
3550 Parkwood Blvd, Ste 110
Frisco, TX 75034

Registration

Patient Information

Mr.	Mrs.	_____		_____
Miss	Ms.	(First, Middle, Last Name)		(Date of Birth)
_____		_____		
(Address)		(City, State, Zip Code)		
_____		_____	_____	
(Home Telephone Number)		(Work Telephone Number)	(Cell Phone Number)	
_____		_____	_____	
(Social Security Number)		(Nickname)	(Prior Name)	
_____		Would you like access to the patient portal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
(E-Mail Address)				
Marital Status: <input type="checkbox"/> Single		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Sex: <input type="checkbox"/> Male		<input type="checkbox"/> Female		
Employment Status: <input type="checkbox"/> Employed		<input type="checkbox"/> Part-time Student	<input type="checkbox"/> Full-time Student	<input type="checkbox"/> Other

Employment Information

_____		_____	
(Occupation)		(Employer)	
_____		_____	
(Address)		(City, State, Zip)	

Spouse Information

_____		_____
(Name)		(Date of Birth)
_____		_____
(Social Security Number)	(Occupation)	
_____		_____
(Employer)		(Employer Phone Number)

Responsible Person (If Applicable)

_____		_____	_____
(Name)		(Date of Birth)	(Relationship to Patient)
_____		_____	
(Address)		(City, State, Zip Code)	
_____		_____	_____
(Phone Number)	(Social Security Number)	(Occupation)	
_____		_____	
(Employer)		(Employer Phone Number)	

Relative to Contact in Case of Emergency (Not Living in Home of Patient)

(Name)

(Phone Number)

(Alternate Phone Number)

(Address)

(City, State, Zip Code)

Relation to patient: _____

Insurance Information

(Name of Insured)

(Date of Birth)

(Relationship to Patient)

(Insurance Company)

(Social Security Number)

(Group Number)

(ID Number)

(Address)

(City, State, Zip Code)

How were you referred to our office?

- By an Attorney
- By a Doctor
- By a Patient
- Other

Please print the name of your source below.

Is your illness or injury related to any of the following?

- Employment
- Emergency
- Accident
- Auto Accident

If Auto Accident, please speak to the receptionist
PRIOR to being seen by physician.

Which pharmacy do you use? _____

Address: _____

Phone: _____

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment.

Financial Responsibility and Assignment of Benefits

I agree to pay all charges for medical and health care services not covered by my insurance company.

I certify that I have read this form and understand its contents.

(Patient or Other Legally Authorized Person)

(Date)