

REGISTRATION

CAMPBELL FAMILY PRACTICE AND GHEBRANIOUS INTERNAL MEDICINE

10950 Resource Parkway, Suite A
Houston Texas 77089
281-484-5587

(Please Print)

PATIENT INFORMATION

Name: _____ Social Security #: _____
Last Name First Name Initial
Address: _____ Apt.# _____ City _____ State _____ Zip _____
Age _____ Date of Birth _____ Home # _____ Cell # _____ Texas Driver's License # _____

PLEASE CIRCLE

GENDER: Male / Female **MARITAL STATUS:** Single / Married / Widowed / Separated / Divorced
RACE: African American / Arabic / Asian / Hispanic / Vietnamese / White / Other: _____
LANGUAGE: Arabic / English / Indian / Russian / Spanish / Vietnamese / Other: _____

Patient Employed by _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Business Phone _____ Email Address _____
In case of emergency who should be notified? _____ Relationship to patient: _____ Phone # _____
PHARMACY: Name _____ Address/Zip _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Date of Birth _____ Social Security # _____
Address (if different from patient) _____ City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____ Texas Driver's License # _____
Business Address _____ City _____ State _____ Zip _____
Business Phone # _____ Names of dependents covered under this plan: _____
Insurance Company _____ Subscriber ID# _____ Group # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes or No Subscribers Name _____
Last First
Address (if different from patient) _____ City _____ State _____ Zip _____
Date of Birth _____ Relationship to Patient _____ Texas Driver's License # _____
Subscribers Phone # _____ Subscriber Employer _____ Occupation _____
Employers Address _____ City _____ State _____ Zip _____
Insurance Company _____ Social Security # _____
Subscriber ID# _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)
And assign directly to Campbell Family Practice all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship: _____ Date: _____