The Clinic At Hilcorp
P:832-521-8862 F:713-647-0621

PATIENT REGISTRATION INFORMATION

Title: _____ First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Address: _____ Address 2: _____ City: _____ State: ____ ZIP: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Driver License #: _____ Social Security#: _____ Email: _____

Pref Language: _____ Ethnicity: _____ Race: _____ Religion: _____

Emergency Contact Name: _____ Phone #: _____ Relationship: _____

Employer: _____ Employer Phone #: _____ Job Title: _____

INSURANCE INFORMATION

Insurance: _____ ID#: _____ Policy/Group #: _____

Insurance Policy Holder Relationship: _____ Insurance Level: _____

If Guarantor is other than self/patient, then enter the following information for policy holder below:

First Name: _____ Last Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____ State ____ ZIP: _____

Home Phone: _____ Employer: _____ Social Security#: _____

MY AUTHORIZATIONS/RESPONSIBILITIES

Place initials before each line:

___To assist us in filing insurance, I certify that the above information is correct. Deductible, co-payment, co-insurance, or non-covered services is my responsibility to pay and that I may be asked for payment at the time of service. I understand that most insurance companies cover annual preventive services at 100% and that any additional medical services (e.g. prescriptions, referrals, detailed physical exams) are not part of the annual preventive visit.

___To assign my insurance benefits to K Dunn and Associates, PA;

___To authorize my practitioners listed in my care plan to share information on my behalf for my care and for billing purposes;

___To authorize the use of telemedicine in my care to the standards of the Texas Medical Practice Act;

___That messages can be left on home or cell phone above;

___That I will identify with my insurance company the names of the doctors to whom I will need referrals;

___That I will make best effort to manage my care as defined in my care plan;

___Fees

o Missed appointment fee $25.00 unless cancelled 24 hours in advance.
o Returned checks will have a $25.00 service charge.
o Disability forms, special insurance forms $15.00 service charge.

**If you have any questions and/or concerns please ask one of our Customer Service Representatives.

Patient Signature/ Authorized Signature for patient: _____ Date: _____