



**PHYSICIANS' CENTER, P. A.**

*Family Medicine & Minor Emergencies*

**Richard C. Male, Jr., D.O**  
and Associates

**3721 Williams Dr.**  
**Georgetown, TX**

**PATIENT REGISTRATION FORM**

Patient \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party (if a minor) \_\_\_\_\_  
Last Name First Name MI

Address \_\_\_\_\_  
Mailing City State Zip Code

Phone w/area code \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

SSN \_\_\_\_\_ Birth date \_\_\_\_\_ E-mail address \_\_\_\_\_

Sex  Male  Female Marital Status  S  M  W  S  D

Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Spouse (or responsible part) Name \_\_\_\_\_ Spouse SSN \_\_\_\_\_

Spouse Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Who should we contact in an emergency? \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION - PLEASE GIVE YOUR CARDS TO RECEPTIONIST FOR COPYING**

Primary Insurance \_\_\_\_\_

Insured's Name \_\_\_\_\_ Birth date \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Insured's Name \_\_\_\_\_ Birth date \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

**IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION**

Date of accident \_\_\_\_\_ How did it happen?  Auto  Work  Other \_\_\_\_\_

Involvement in Accident if Auto  Driver  Passenger  Pedestrian  Cyclist

Attorney's Name/Address/Phone \_\_\_\_\_

Insurance Company (workers' comp or your auto PIP) \_\_\_\_\_

Address \_\_\_\_\_ Phone number \_\_\_\_\_

Claim Number \_\_\_\_\_ Adjuster \_\_\_\_\_

Name of insured (employer if w/c) \_\_\_\_\_

If this is workers' comp, have you reported this injury to your employer?  Yes  No

What is your reported injury?(body part) \_\_\_\_\_

**How did you learn of our practice?** \_\_\_\_\_

**ASSIGNMENT and RELEASE**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to **PHYSICIANS' CENTER, P.A.** all medical payments and benefits 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 release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: \_\_\_\_\_ for any services furnished by that physician/supplier. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "the other health insurance" is indicated in box 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and this patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**Patient** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Signature**

**Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Signature (if a minor)**