

**SOUTHWEST INTERNAL MEDICINE SPECIALISTS**

Diplomats, American Board of Internal Medicine

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**PATIENT REGISTRATION (UPDATE 2009)**

PATIENT NAME \_\_\_\_\_  
Last First Initial

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

Male/Female \_\_\_\_\_ Social Security Number \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Telephone \_\_\_\_\_

**Friend or Relative not living With You:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

**Medical Insurance Information:**

1. Primary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_

2. Secondary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_

Name of Spouse or (if a minor) parent \_\_\_\_\_

Spouse's/Parent's Employer \_\_\_\_\_ Telephone \_\_\_\_\_

**Authorization and Assignment**

I hereby authorize my insurance carrier, attorney or any third-party payer to pay directly to Southwest Internal Medicine Specialists all charges submitted for services incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company. I authorize Southwest Internal Medicine Specialists to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to the physicians at Southwest Internal Medicine Specialists which may be due from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. The authorization and assignment shall be valid until I notify Southwest Internal Medicine Specialists in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

\_\_\_\_\_  
Signature Date Signature (WITNESS) Date