New Patient Account Information

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

General Information

Print and fill out this form to register as a new patient with River Hills Family Medicine. All fields with an asterisk (*) are required Fields. We cannot register you as a patient without this information. Please fax the completed form to our office at (512) 346-7436.

Please call our office manager at 345-7436 with any questions.

Patient Information

Appointment Date:		Soc. Sec. No.:*	
Address:*		Sex: (male or female)	
City, State, Zip:*		Marital Status:*	
Home Phone:*		Employment Status:*	
Alternate Phone:		Preferred Phone No.:	
Employer/School:*		Occupation:	
Address:		E-mail::	
City, State, Zip:			

Guarantor Information (person responsible for the bill)

First/Last Name:*		Soc. Sec. No.:*	
Address:*		Date of Birth:*	
City, State, Zip:*		Sex: (male or female)	
Home Phone:*		Marital Status:	
Alternate Phone:		Employment Status:	
Employer/School:		Preferred Phone No.:	
Address:		Occupation:	
City, State, Zip:		Relation to Patient:	

Subscriber Information (person that has the policy)

First/Last Name:*		Soc. Sec. No.:*	
Address:*		Date of Birth:*	
City, State, Zip:*		Sex: (male or female)	
Home Phone:*		Marital Status:	
Alternate Phone:		Employment Status:	
Employer/School:*		Preferred Phone No.:	
Address:		Occupation:	
City, State, Zip:		Relation to Patient:	

Please return completed form to the appropriate physician's office.

CONFIDENTIAL

New Patient Account Information, cont'd.

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

Primary Coverage

Subscriber:* _____ Plan Type: _____

Insurance Company:* _____ Policy ID Number: _____

Claims Address:* _____ Patient ID Number:* _____

City, State, Zip:* _____ Group Number:* _____

Phone:* _____ Office Visit Co-pay: _____

Patient's PCP:* _____ Verified by: _____

Effective Dates: _____

Secondary Coverage

Subscriber: _____ Plan Type: _____

Insurance Company: _____ Policy ID Number: _____

Claims Address: _____ Patient ID Number: _____

City, State, Zip: _____ Group Number: _____

Phone: _____ Office Visit Co-pay: _____

Patient's PCP: _____ Verified by: _____

Effective Dates: _____

Emergency Contact

First/Last Name:* _____ Home Phone:* _____

Address: _____ Alternate Phone: _____

City, State, Zip: _____ Relation to Patient:* _____

Patient Signature:_____ Date:_____

If someone other than the patient completed this form, please give name & relationship: _____
Name Relationship

Information Obtained by: _____ Date:_____

Account Created by:_____ Date:_____

Provider Signature:_____ Date Reviewed:_____

Please return completed form to the appropriate physician's office.