Copperfield Family Medicine, P.A.

7555 Cherry Park Drive
Houston, Texas 77095
Phone:(281) 345-4747

PATIENT REGISTRATION

Welcome to our office! Please complete the following: Today's Date : _____

Personal Information:

Name (Last, First, Middle In.)	Soc. Sec. #	Date of Birth (M/D/Y)	Marital Status
	- -	/ /	

Address (Include Apt. #)	City	State	Zip Code

Employer	Address	City	State	Zip Code

Home Phone #	Work Phone #	Cell Phone #	Best Number to Use M-F, 9-5:
( ) -	( ) -	( ) -	HOME / WORK / CELL

Name of Spouse or Parent	Soc. Sec. #	Date of Birth (M/D/Y)
	- -	/ /

Employer of Spouse or Parent	Work Phone #	Referred to our office by:
	( ) -	

Insurance Information:

Health Insurance Company (Primary)	Name of Family Member Providing Insurance	Policy #	Group #

Health Insurance Company (Secondary)	Name of Family Member Providing Insurance	Policy #	Group #

Emergency Information:

Who should be notified?	Relationship	Phone #
		( ) -

Do you have any MEDICATION ALLERGIES? (Please list)	What is the reaction if taken?

Preferred Pharmacy	Location	Phone #
		( ) -

Persons I Wish to Have Access to My Medical Information:

Persons listed here will have access to your appointment information, medical records and test results.

Name	Relationship

Authorization and Consent / Assignment and Release:

I give consent to Copperfield Family Medicine, P.A. to treat, administer drugs, and order x-rays and other lab tests that are necessary in the opinion of the physicians to care for me. I understand that insurance billing is performed as a courtesy and is no guarantee of payment for services. Furthermore, I understand that *I am responsible* for all fees, regardless of insurance coverage, and that it is customary to pay for services that are not covered by insurance when rendered. Failure to pay outstanding balances in a timely manner will result in collections activity. I agree to reimburse Copperfield Family Medicine the fees of any collection agency, which may be based on a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts. I authorize the release of any medical information necessary to process my insurance claims and authorize payment of benefits directly to Copperfield Family Medicine, P.A. or its physicians. I am aware that it is mandatory to disclose any party who may be responsible for paying for my treatment. I authorize the use of this signature on all insurance submissions. Finally, I understand that I will be charged a $25 fee if I fail to give at least 24 hours notice prior to canceling a standard appointment (or a $50 fee in the case of a well-woman exam or CIMT scan).

_____ _____
Signature Date