**REGISTRATION**

# RESPIRATORY CONSULTANTS OF HOUSTON

PLEASE PRINT **CLEARLY**

**SMITH TOWER**
6550 Fannin St., Suite 2403 ◊ Houston, Texas 77030
**Telephone: (713) 790-6250 ◊ Fax (713) 793-1538**

**MD:**_____

## PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) Birthdate _____ Sex ☐ M ☐ F

Address _____ Apt _____ **Home T** (___) ___ – ____

City _____ State _____ Zip _____ **Cell** (___) ___ – ____

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor Soc.Sec. # ___ – ___ – ____

☐ Partnered for ____ years E-mail _____ @ _____

Patient Employer/School _____ ☐ Retired Occupation _____

Work/School Address _____ Wk/Sc Tel (___) ___ – ____

Whom may we thank for referring you? ☐ Physician ☐ Attorney ☐ Company | Name _____

In emergency, call _____ Relationship _____ Phone (___) ___ – ____

## PRIMARY INSURANCE

Name of Insured _____ (Last Name / First Name / Middle Initial)

Relation to patient _____ Birthdate _____ Soc.Sec. # ___ – ___ – ____

Primary Insurance Company _____ Insur. Tel (___) ___ – ____

Member ID _____ Group # _____ Effective Date _____

Insured Address (If not patient's) _____ Phone (___) ___ – ____

City _____ State _____ Zip _____ Occupation _____

Insured Employer _____ Work Tel (___) ___ – ____

## SECONDARY INSURANCE

Insured Name _____ DOB _____

Secondary Insurance Company _____

Member ID _____ Group # _____

Insurance Tel (___) _____ Effective Date _____

## PHARMACY INFORMATION

Pharmacy Name _____

Phone (___) ___ – ____

Fax (___) ___ – ____

Address _____

City _____ ST ____ ZIP _____

## TERTIARY INSURANCE

Insured Name _____ DOB _____

Tertiary Insurance Company _____ Insur. Tel (___) ___ – ____

Member ID _____ Group # _____ Effective Date _____

## AUTHORIZATION

Effective August 1, 2000, House Bill 610 (Prompt Pay Law) became effective. To be in compliance with this law, it is mandatory that we verify patient health insurance information.

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ DATE

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

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