



**1215 S Coulter Street
Amarillo, TX 79106**

REGISTRATION FORM

(Please Print)

Today's Date:		Primary Care Physician:					
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Email Address:			Cell phone no.: ()		Work phone no.: ()		
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen by our practice: (This enables us to link charts of Spouses and minor children)							

INSURANCE INFORMATION								
(Please give your insurance card to the receptionist.)								
Person responsible for bill:		Birth date:		Address (if different):		Home phone no.: ()		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Occupation:		Employer:		Employer address:		Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Please indicate primary insurance		<input type="checkbox"/> Aetna	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> First Care	<input type="checkbox"/> United	<input type="checkbox"/> IMS		
<input type="checkbox"/> Humana	<input type="checkbox"/> Medicare	<input type="checkbox"/> GEHA	<input type="checkbox"/> Medicaid (Please provide card)		<input type="checkbox"/> Other			
Subscriber's name:		Subscriber's S.S. no.:		Birth date:	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):			Subscriber's name:			Group no.:		Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			

ADDITIONAL INFORMATION

Preferred Local Pharmacy: Address: City:	Other Preferred Mail Order Pharmacy: Address: City:
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Mail Order Pharmacy: Medco Caremark Express Scripts Other:

Would you like to sign up for the web Patient Portal so you can view your Lab results? Yes No

We are now required by CMS to collect information on race and ethnicity. How do you want to be listed?	<input type="checkbox"/> American Indian or Native Alaskan	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic
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<input type="checkbox"/> Decline to State	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other
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Any Special Needs?

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Amarillo Medical Specialists, LLP, my physician, or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date