Hunt Regional Medical Partners
4501 Joe Ramsey Blvd, Ste 100
Ph:903-408-5800 Fax:903-455-8232

For Office Use Only:
Account #:

Patient Registration Form

Patient Information:

First Name:_____ MI:_____ Last Name:_____
Social Security #:_____-_____-_____ Date of Birth:_____ Male ☐ Female ☐
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Single☐ Married☐ Widowed☐ Divorced☐ Separated☐

Responsible Party:

First Name:_____ MI:_____ Last Name:_____
Social Security #:_____-_____-_____ Date of Birth:_____ Male ☐ Female ☐
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Relationship to Patient:_____
Employer:_____ Employer Address:_____

Patient Employment Information:

Occupation:_____ Employer:_____
Employers Address:_____ Student ☐

Primary Insurance Information:

Name of Insurance:_____ Phone #:_____
Policy #:_____ Group #:_____ Effective Date:_____
Subscriber:_____ Date of Birth:_____ SS#:_____-_____-_____
Relationship to Patient:_____ Employer:_____

Secondary Insurance Information:

Name of Insurance:_____ Phone #:_____
Policy #:_____ Group #:_____ Effective Date:_____
Subscriber:_____ Date of Birth:_____ SS#:_____-_____-_____
Relationship to Patient:_____ Employer:_____

Additional Information:

Driver's License #:_____
Emergency Contact:_____
Emergency Contact Ph #:_____
Primary Care Physician:_____
Primary Care Physician Ph #:_____

I understand that it is my responsibility to provide my current insurance information. Copays and deductibles are due and payable at the time of service. I understand that not all services may be covered by my insurance. I will be financially responsible for all non-covered services. 24 hour notice is required for cancellation without penalty. The penalty for not cancelling with proper notice is $25.00 per occurrence plus loss of right to preferred appointment dates/times.

I hereby assign all medical and/or surgical benefits including Medicare, private insurance, and any other health plan to Hunt Regional Medical Partners. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment for services rendered.

Print Name:_____ Signature:_____ Date:_____