PATIENT INFORMATION FORM

CHRISTUS Physician Group

TODAY'S DATE (mm/dd/yyyy): _____ / _____ / _____

PATIENT INFORMATION

Last Name	First Name	Preferred Name	MI

Date of Birth	Driver's License Number	Social Security #
	N/A	

Gender: [ ] Male [ ] Female Marital status (Check one) [ ] Single [ ] Married [ ] Divorced [ ] Widow(er) [ ] Partner [ ] Separated [X] Unknown

Home Street Address	City	State	Zip Code

Home #	Work #	Cell #	Email
			N/A

Preferred Language: [ ] English [ ] Spanish [ ] Vietnamese [ ] Other

Contact Preference: [ ] Home Phone [ ] Work Phone [ ] Mobile Phone [ ] Mail [ ] Portal

Chose clinic because / Referred to clinic by (please check one box): [ ] Physician [ ] Insurance Plan [ ] Hospital [ ] Yellow Pages [ ] Family [ ] Friend [ ] Close to home / work [ ] Other_____

RESPONSIBLE PARTY / GUARANTOR INFORMATION

[ ] Check here if same as above

Guarantor Name	Address

Patient's relationship to Guarantor

[ ] Self [ ] Spouse [ ] Child [ ] Other_____

NEXT OF KIN

Name	Relationship	Phone

INSURANCE INFORMATION

Please complete items below if Not included on Insurance card(s)

Primary Insurance	ID certification #

Insurance Address

SEE ATTACHED CARD COPY - FRONT/BACK

Subscriber's name	Birthdate	Policy / Group #	Co-pay
			$_____

Patient's relationship to policy holder

[ ] Self [ ] Spouse [ ] Child [ ] Other _____

Secondary Insurance (if applicable)	ID certification #

Insurance Address

Subscriber's name	Birthdate	Policy / Group #	Co-pay
			$_____

Patient's relationship to policy holder

[ ] Self [ ] Spouse [ ] Child [ ] Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home #	Work / Cell #

I hereby authorize payment directly to C.H. Wilkinson Physician Network for any surgical and/or medical benefits, if any, otherwise payable to me. I also authorize C.H. Wilkinson Physician Network to file all necessary papers for insurance and to release any and all copies of medical records requested by my insurance company for the purpose of determining benefits. I understand such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues. I acknowledge full responsibility for the payment of such services and agree to pay my bill in full AT THE TIME OF SERVICES unless other arrangements are made with the financial department.

* Patient / Guardian Signature	Date