KATY DIABETES AND ENDOCRINOLOGY

Patient Registration Form

Patient Information

Last Name:	First Name:	M.I.
Mailing Address:		
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Preferred Method of Contact:		
Social Security #:	Date of Birth:	
Marital Status:	Sex: ☐ Male ☐ Female ☐ Transgender	
Primary Care Physician:		
Preferred Pharmacy:		
Emergency Contact Name:	Emergency Contact Number:	Relationship to Patient:

Insurance Information

Primary Insurance Name:	ID #:	Group #
Policy Holder Name:	Policy Holder Date of Birth:	Policy Holder SSN:
Secondary Insurance Name:	ID #:	Group #:
Policy Holder Name:	Policy Holder Date of Birth:	Policy Holder SSN:

Responsible Party

Last Name:	First Name:	
Date of Birth:	SSN:	Phone:
Address:		
City/State/Zip:	Relationship to Patient:	

Additional Information

Email Address:	
Ethnicity: ◻ White ◻ Black or African American ◻ American Indian or Alaska Native ◻ Asian ◻ Native Hawaiian or Other Pacific Islander	Preferred Language: ◻ English ◻ Spanish ◻ Sign Language ◻ Hindi ◻ Other _________
I certify I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Katy Diabetes and Endocrinology all money to which I am entitled for medical expenses related to the services performed from time to time by Katy Diabetes and Endocrinology. I authorize Katy Diabetes and Endocrinology to release any medical information to my insurance carrier or third party payer to facilitate processing of my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.	
Patient Signature:	Printed Name:
Date:	