

Liver Specialists of Texas, P.A.

REGISTRATION FORM

(Please Print)

Today's Date ____/____/____

PCP _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	

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
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Street Address	City	State	ZIP Code	Social Security	Home Phone No. ()
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P.O. Box	City	State	ZIP Code
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Occupation	Employer	Employer Phone No. ()
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Chose This Practice Because/Referred to Dr. Galati by:
(Please check one box)

Family
 Friend
 Close to Home/Work
 Yellow Pages
 Other _____

Dr. _____
 Insurance Plan
 Hospital

Other Family Members Seen Here _____

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. ()
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Is this patient covered by insurance? Yes No

Please indicate primary insurance

[Insurance]
 [Insurance]
 [Insurance]
 [Insurance]
 [Insurance]

[Insurance]
 [Insurance]
 [Insurance]
 Welfare
 Other _____

(Please provide coupon)

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
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Patient's Relationship to Subscriber
 Self
 Spouse
 Child
 Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #
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Patient's Relationship to Subscriber
 Self
 Spouse
 Child
 Other _____

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 **LIVER SPECIALISTS OF TEXAS** or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE
DATE