Sim Family Clinic, P.A.
4331 Brightwood Dr, Ste 100
Houston, TX 77068
(281) 893-5870
www.simmd.com

Patient Registration Form

Today's Date: _____

Patient Information

Name: _____ Social Security No: _____
Last Name First Name M.I.

Address: _____

City: _____ State: _____ Zip: _____

Primary phone number: _____ Secondary phone number: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: ____ /____ /_____

Marital Status (circle): Single Married Widowed Separated Divorced

Occupation: _____ Employer: _____

In case of emergency, who should be notified? _____ Ph# _____

PRIMARY INSURANCE INFORMATION

Person Responsible for the Account (Subscriber): _____
Last Name First Name M.I.

Relation to patient: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Occupation: _____

Business Address: _____ Business ph#: _____

Insurance Company Name: _____

Subscriber #: _____ Policy/Group #: _____

Names of other dependants on this plan: _____

OTHER INSURANCE

Is the patient covered by other insurance? (circle) Yes No

Subscriber Name: _____ Relation to the patient: _____

Address (if different than the patient's): _____

Ph#: _____

Insurance company name: _____

Subscriber #: _____ Policy/Group #:_____

Names of other dependants on this plan: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependants) have insurance coverage, and assign directly SIM FAMILY CLINIC, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that SIM FAMILY CLINIC, P.A. is authorized to release all information necessary to secure proper payment benefits.

_____	_____	_____
Responsible Party signature	Responsible Party printed name	Relation to patient