Patient Registration

Clover Internal Medicine Associates, 800 8th Avenue, suite 506
Fort Worth, TX 76104
(817) 386 - 3632

PATIENT NAME: _____

DOB:_____SEX:[ ]M [ ] F SS#_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL:_____WORK:_____

EMAIL ADRESS:_____

HOW DID YOU FIND US/REFERRED? _____ (ex. Website, family member, etc.)

SPOUSE/PARTNER NAME:_____

POLICY CARD HOLDER INFORMATION:

NAME: _____ DOB:_____

RELATIONSHIP: _____

SHOULD THERE BE AN EMERGENCY, WHOM SHOULD WE CONTACT:

1) NAME:_____RELATIONSHIP:_____

HOME PHONE:_____CELL:_____WORK:_____

2) NAME:_____RELATIONSHIP:_____

HOME PHONE:_____CELL:_____WORK:_____

CO-PAY DUE UPON VISIT:

I HAVE BEEN GIVEN THE OPPORTUNITY TO READ YOUR PRIVACY INFORMATION AND AUTHORIZE YOU TO DISCUSS MY MEDICAL INFORMATION WITH THOSE INDIVIDUALS LISTED ABOVE. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR THE CHARGES INCURRED AT THIS FACILITY AND PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. SHOULD I BE HOSPITALIZED I AUTHORIZE MEDICAL BENEFITS TO BE PAID DIRECTLY TO THIS FACILITY.

I hereby assign, transfer, and set over to Clover Internal Medicine Associates all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____

PATIENT SIGNATURE DATE

PATIENT PORTAL

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*****PLEASE PRINT YOUR NAME, DOB, AND EMAIL TO PARTICIPATE IN THE PATIENT PORTAL. IF YOU WANT TO OPT OUT, THEN WRITE "NO".**

PATIENT NAME: _____

DATE OF BIRTH: _____

EMAIL ADDRESS: _____

MY MEDICATION LIST

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

ALLERGIES: _____

MEDICATION	DOSAGE	DIRECTION