



Allergy and Family Medicine

PO Box 913 San Marcos, TX 78667
512-396-2125 Fax 512-396-2126

Patient Registration Information

Date: _____

Last Name _____ First Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

DOB _____ Age _____ Sex: M F Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Marital Status _____

Employed By _____ Pharmacy/Phone _____

Family Physician _____ Phone _____

Health Insurance Carrier _____ ID _____ Group _____

Cardholder/Responsible Party

Responsible Party Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

DOB _____ SSN _____ Relationship to Patient _____

Employed by _____

Emergency Contact

Name _____ Relation to Patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Please update the office regarding any new health care conditions, new medications, or any allergies to any medications, or if you are pregnant.

Insurance Authorization and Assignment

I hereby authorize *Allergy and Family Medicine, PA* to furnish information to my insurance carrier(s) concerning my illnesses and treatment. I will be responsible to the physician for all payments of medical services not covered by insurance. I hereby authorize that photocopies of this form are as valid as the original.

Print Name _____

Signature _____ Date _____

Please tell us how it is you heard about us _____