REGISTRATION
(PRINT PLEASE)

WESTOVER HILLS CLINIC

1911 Rogers Road
San Antonio, TX 78251
Tel 210.523.9933 I Fax 210.647.0242

PATIENT INFORMATION

Last Name_____ First Name _____Middle Initial ____SSN_____

Address _____ City _____ State ____ Zip _____

Home Phone _____Cell Phone _____e-mail_____

SEX___M__F AGE___ Date of Birth _____ ___ Married ____ Widowed _____Single ____Divorced ___Minor

Patient employer/ School _____Occupation _____

Employer/School address_____ Employer/School Phone_____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____Phone _____

PRIMARY INSURANCE

Person responsible for account _____

Relation to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from patient's) _____Phone # _____

City _____State _____Zip _____

Person Responsible Employed by _____Occupation _____

Business Address _____Business Phone _____

Insurance Company _____ Business Phone _____

Contract# _____Group # _____Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? _____ Yes _____No

Subscriber Name _____Birthdate _____Relation to patient _____

Address (if different from patient's) _____

City _____ State _____ Zip _____

Insurance company _____ Soc Sec. # _____

Contract # _____Group # _____Subscriber #_____

ASSIGNMENT AND RELEASE

I have supplied correct information and will notify staff of any changes. I authorize Westover Hills Clinic, PA through its personnel to render health care services to me in the form of examinations and treatments. I authorize Westover Hills Clinic, PA to disclose health care information to the above insurance company for the purposes of obtaining payment for services rendered.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of Patient, Parent, Guardian or Personal Representative