Your HEALTHCARE Place

New Patient Information

1813 Hinkle Dr, Suite 100
Denton, TX, 76201
Ph: (940) 312-7266 Fax: (940)312-7266

PATIENT INFORMATION

Patient Name: ______________________________ Sex: ☐ M ☐ F Social Security No: _______/______/_______

Marital Status: ☐ Single ☐ Married ☐ Widow/er ☐ Divorced ☐ Partner Date of Birth: ______/______/________ Age: _______

Race: ________________________ Ethnic Group: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language if not English: _________________________ Other communication issues? ☐ Yes ☐ No What ____________________

Mailing Address: ____
Street Apt. No. City State Zip

Physical Address (if not same as mailing): ______________________________
Street City State Zip

Home Phone: (_____) ______ - ____________ Cell/Pager No.: (_____) ______ - _____________ Work Phone: (_____) _____ - ____________

E-Mail Address: ____________________________ Preferred Contact Method: ☐ Text ☐ Mail ☐ E-Mail ☐ Phone

Reminder Method: ☐ Work Phone ☐ Home Phone ☐ Cell Phone ☐ E-Mail Drivers License No.: ______________ _______ Expires: _________
Number State

Spouse/Partner Name: ______________________________ Date of Birth: ______/_____/_______ Social Security No.: ______/______/_______

Address: ____ Work Phone: (______) ________ - _______________

Emergency Contact Name: ______________________________ Emergency Contact Phone: (______) ________ - _______________

Address: ____ Relationship: ______________________________

GUARANTOR/PARENT INFORMATION

Responsible Party Name: ______________________________ Date of Birth: ______/____/______ Sex: ☐ M ☐ F Social Security No.: _____/____/______

Marital Status: ☐ Single ☐ Married ☐ Widow/er ☐ Divorced ☐ Partner Drivers License No.: ___________ _______ Expiration Date: _________
Number State

Home Phone: (_____) ______ - ____________ Cell/Pager No.: (_____) ______ - _____________ Work Phone: (_____) _____ - ____________

Address: ____

Employer: ____ Occupation: ______________________________

Address: ____ Relationship to Patient: ______________________________

PATIENT'S INSURANCE INFORMATION (Please provide Insurance Card and Photo ID to Receptionist)

Primary Insurance Company's Name: ____

General Phone: (_____) ______ - ____________ Claims Phone.: (_____) ______ - _____________Office Fax: (_____) _____ - ____________

Insurance Address: ____
Street Suite No. City State Zip

Policy Holder: ______________________________ Date of Birth: _____/_____/_______ Social Security No.: _______/______/________

Insurance ID No.: ______________________________ Insurance Group No.: ______________________________

Secondary Insurance Company's Name: ____

General Phone: (_____) ______ - ____________ Claims Phone.: (_____) ______ - _____________Office Fax: (_____) _____ - ____________

Insurance Address: ____
Street Suite No. City State Zip

Policy Holder: ______________________________ Date of Birth: _____/_____/_______ Social Security No.: _______/______/________

Insurance ID No.: ______________________________ Insurance Group No.: ______________________________

Referred By: (please check) ☐ Family ☐ Friend ☐ Hospital ☐ Ad ☐ Other: ______________________________

Would you like to sign up for patient portal?

☐ Yes ☐ No

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