Rio Grande Medicine

Caring. For life.

NEW PATIENT REGISTRATION FORM

Last Name: _____ **First Name:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

DOB: _____ **Social Security #:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Marital Status: ( ) Married ( )Single( )Widowed ( ) Divorced

Emergency Contact: _____ **Relationship:** _____

Tel:_____ **Address:** _____

City:_____**State:**_____**Zip:** _____

Medical Insurance Information (Please present insurance card on the day of appointment)

Primary Insurance: _____ **Policy #:**_____

Group # _____ **Insured Name:** _____

DOB: _____ **Relationship to patient: ( ) SELF ( )SPOUSE**

Secondary Insurance: _____ **Policy #:** _____

Insured Name: _____ **DOB:** _____

Group # _____ **Relationship to patient: ( ) SELF ( ) SPOUSE**

_____

Patient Employer: _____ **Occupation:** _____

Employer Address: _____ **Work Tel:** _____

City: _____ **State:** _____**Zip:**_____

I understand and agree that I will be RESPONSIBLE for payments of all charges incurred. We request that all office visits be paid at the time of service. We look to you for payment of any services rendered. We do not hold secondary insurance companies responsible for payment.

Patient Signature: _____ **Date:** _____

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