Arturo A. Bravo, MD
Gastroenterology

Arturo Bravo, M.D., P.A.
11307 FM 1960 West, Suite 370
Houston, TX 77065

Patient Registration Form

Please Print

Welcome to Our Practice

Date _____ Home Phone_____ Cell Phone_____

Patient _____ Last
Name First Name Initial

Responsible Party (if patient is a minor) _____

_____

Street Address _____

_____

City _____ State _____ Zip _____Sex ❑ M ❑ F Age ___

_____

Birth Date _____ ❑ Single ❑ Married ❑ Divorced

Social Security # _____Spouse's Social Security # _____

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

Spouse Employed By _____

Business Address _____

Occupation _____ Business Phone _____

With whom may we share information about your account? Name_____

Relationship _____ Phone _____

With whom may we share your medical records? Name _____

Relationship _____ Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Do you have Medical Insurance? _____

Name of Policy Holder _____

Name of Insurance Company _____

Policy # _____ Group # _____Subscriber # _____

Name of Secondary Insurance Company (if any) _____

Policy # _____ Group # _____ Subscriber # _____

❑ Medicare # _____ ❑ Medicaid # _____

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Patient Registration Form, Continued

How were you referred to our practice? ❑ Friend/Relative, if so, name: _____

❑ Yellow Pages ❑ Physician, if so, name: _____ ❑ Receiving Mail

❑ Newspaper ❑ Hospital referral ❑ Other? _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with insurer).

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have received notice of this organization's privacy policies.

Signature: _____ Date: _____