SOUTH TEXAS TMS, LLC (GRACE SALINAS-GARCIA, MD)

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
❑ Yes	❑ No			/ /		❑ M ❑ F

Street address:	Social Security no.:	Home phone no.:
		( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

How did you learn about our practice? (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	/ /		( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ AETNA ❑ BCBS ❑ HUMANA ❑ TRICARE ❑ UBH

❑ VALUE OPTION ❑ MEDICAID ❑ MEDICARE ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize South Texas TMS, LLC (Grace Salinas-Garcia, MD) or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*