Anthony T. Machi, M.D.
3509 Hulen Street #207
Fort Worth, Texas 76107

___ New Patient Registration
___ Established Patient Update

PATIENT REGISTRATION FORM
MINORS AND ADULT DEPENDENTS

Date: _____

Who referred you to this office? _____

Patient Information:

Name: _____ Gender: M F
First Middle Last

Address: _____

City/State/Zip Code: _____

Phone: (___)_____/(___)_____/(___)_____
Home Mobile Pager

Date of Birth: ____/____/____ Age: _____

School: _____

Address: _____

Employer: _____

Address: _____

Phone: _____ Work Hours: _____

Occupation: _____ Length of Employment _____

Name of person responsible for this account: _____

With whom does the patient reside (circle one)?

Mother Father Both Guardian

If multiple locations, list days and hours at each location: _____

_____

_____

Mother Information (If step-parent/guardian, please advise):

Name: _____
First Middle Last

Address: _____

City/State/Zip Code: _____

Phone: (___)_____/(___)_____/(___)_____
Home Mobile Pager

At what numbers may we contact and/or leave a voicemail message for you?

HOME WORK MOBILE PAGER

****TURN OVER TO COMPLETE****

Date of Birth: ____/____/____ Age: _____

Marital Status (circle one) M S D W

Employer: _____

Address: _____

Phone number: _____ Work Hours: _____

Occupation: _____ Length of employment_____

Father Information (If step-parent/guardian, please advise):

Name: _____
First Middle Last

Address: _____

City/State/Zip Code: _____

Phone: (___)_____/(___)_____/(___)_____
Home Mobile Pager

At what numbers may we contact and/or leave a voicemail message for you?

HOME WORK MOBILE PAGER

Date of Birth: ____/____/____ Age: _____

Marital Status (circle one) M S D W

Employer: _____

Address: _____

Phone number: _____ Work Hours: _____

Occupation: _____ Length of employment_____

Emergency Contact (Someone not within your home):

Name: _____

Address: _____

Phone: _____/(___)_____/(___)_____

Home Mobile Pager

AUTHORIZATION FOR RELEASE OF INFORMATION TO FACILITATE PATIENT REIMBUMRSEMENT:

I authorize Anthony T. Machi, M.D., to release any information to my insurance company necessary to assist me in reimbursement for the fees paid by me for evaluation and treatment. I understand that this authorization will remain in effect until I revoke this release in writing.

_____ _____

Date Signature of Responsible Party