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

____ New Patient Registration
____ Established Patient Update

PATIENT REGISTRATION FORM- ADULT

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

At what numbers may we contact and/or leave you a voice mail message for you?
Home Work Mobile Pager

Date of Birth: ____/____/____ Age: _____ Social Security#____-____-_____

Employer:_____

Address: _____

Work Phone#: _____ Work Hours: _____

Occupation: _____ Length of Employment _____

Marital Status (Circle One): M S D W

Name of party responsible for this account: _____

SPOUSE/PARTNER INFORMATION

Name: _____ Gender: M F
First Middle Last

Address: _____

City/State/Zip Code: _____

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

At what numbers may we contact and/or leave you a voice mail message for you?
Home Work Mobile Pager

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

Date of Birth: ____/____/____ Age: _____ Social Security#____-____-_____

Employer:_____

Address: _____

Work Phone#: _____ Work Hours: _____

Occupation: _____ Length of Employment _____

Marital Status (Circle One): M S D W

Emergency Contact (<u>Someone *not* within your home</u>):

Name: _____ Gender: M F
First Middle Last

Address: _____

City/State/Zip Code: _____

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

Relationship to patient: _____

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.

_____ _____

Signature of Patient Date