JVC Family Medicine
17376 Northwest Freeway
Houston, Texas 77040-1114

Registration

Patient Information

Mr. Mrs.
Miss Ms. _____ _____
(First, Middle, Last Name) *(Date of Birth)*

_____ _____
(Address) *(City, State, Zip Code)*

_____ _____ _____
(Home Telephone Number) *(Work Telephone Number)* *(Cell Phone Number)*

_____ _____ _____
(Social Security Number) *(Nickname)* *(Maiden/Prior Names)*

_____ Would you like access to the patient portal? ☐ Yes ☐ No
(E-Mail Address)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Sex: ☐ Male ☐ Female
Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employment Information

_____ _____
(Occupation) *(Employer)*

_____
(Address) *(City, State, Zip)*

Spouse Information

_____
(Name) *(Date of Birth)*

_____
(Social Security Number) *(Occupation)*

_____ _____
(Employer) *(Employer Phone Number)*

Responsible Party/Person (If Applicable)

_____ _____ _____
(Name) *(Date of Birth)* *(Relationship to Patient)*

_____ _____
(Address) *(City, State, Zip Code)*

CONTINUED

JVC Family Medicine
17376 Northwest Freeway
Houston, Texas 77040-1114

Responsible Party/Person Continued

_____ _____ _____
(Phone Number) *(Social Security Number)* *(Occupation)*

_____ _____
(Employer) *(Employer Phone Number)*

Relative to Contact in Case of Emergency (Not Living in Home of Patient)

_____ _____ _____
(Name) *(Phone Number)* *(Alternate Phone Number)*

_____
(Address) *(City, State, Zip Code)*

Relation to patient: _____

Insurance Information

_____ _____ _____
(Name of Insured) *Date of Birth)* *(Relationship to Patient)*

_____ _____ _____ _____
(Insurance Company) *(Social Security Number)* *(Group Number)* *(ID Number)*

_____
(Address) *(City, State, Zip Code)*

How were you referred to our office?

- ☐ By an Attorney
- ☐ By a Doctor
- ☐ By a Patient
- ☐ Other

Please print the name of your source below.

Is your illness or injury related to any of the following?

- ☐ Employment
- ☐ Emergency
- ☐ Accident
- ☐ Auto Accident

Which pharmacy do you use?

_____

Address: _____**Phone:**_____

JVC Family Medicine
17376 Northwest Freeway
Houston, Texas 77040-1114

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment.

Financial Responsibility and Assignment of Benefits

I agree to pay all charges for medical and health care services not covered by my insurance company.

I certify that I have read this form and understand its contents.

_____ _____

(Patient or Other Legally Authorized Person) ***(Date)***