HOUSTON MEDICAL CLINIC
PATIENT REGISTRATION FORM

9889 Bellaire Blvd Ste E219A, Houston, TX 77036 - phone 713-272-6688 - fax (713) 271-6689 - houstonmedicalclinic.com

Last Name *Apellido* 姓氏		**First Name** *Nombre* 名字	
Middle Name *Segundo nombre* 中間名		**Date of Birth** *Nacimiento* 出生日	**Age:** *Edad* 年齡
Gender *Sexo* 性別	Legal 法定: ☐ **M** *Hombre* 男 ☐ **F** *Mujer* 女 Identity *Identida* 認同:	**SSN** *Seguro social* 社會安全號碼	
Address *Dirección* 地址			
City *Ciudad* 城市 **State** *Estado* 州縣		**Zip Code** *Código postal* 郵編	
Race/Ethnicity *Etnicidad* 種族		**Main Language** *Lenguaje* 首選語言	☐ English ☐ Mandarin 普通話 ☐ Español ☐ Other:
Marital Status *Estado civil* 婚姻狀況	☐ Single *Solo* 單身 ☐ Married *Casado* 已結 ☐ Divorced 離婚 ☐ Decline *No decir* 不說 *Divorciado*	**Mobile Phone** *Celular* 手機號碼 **Home** 家用電話	☐ **Receive Texts** *Recibir texto* 收簡訊
Email 電子郵件		**Occupation** *Ocupación* 職業	
Employer *Empleador* 雇主		**Work Address** *Dirección* 工作地址	
Pharmacy *Farmacia* 藥房		**Phone** *Telefono* 電話	
Primary Insurance Holder *Titular del seguro* 主要健保持有人	☐ Name above 名字如上 *Nombre como arriba*	**Phone** *Telefono* 電話 **DOB** *Fec Nac* 出生日 **Relationship** 關係	
Emergency Contact *Emergencia* 緊急聯絡人		**Phone Number** *Telefono* 電話號碼	

CONSENT TO MEDICAL TREATMENT – I hereby authorize Houston Medical Clinic / HMC Medical Associates, PLLC / Universal Med-Health Services, Inc. and their employees, agents and otherwise affiliates to administer any treatment, and perform such other actions as the provider may deem necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine, the healing arts, and ancillary care are not exact sciences and I acknowledge that no warranty, guarantee or assurance has been made by the clinic or provider as to the results of the treatments, examination or otherwise that may be obtained. I understand that nonadherence with treatment plans and appointments may result in clinic dismissal.

ASSIGNMENT OF INSURANCE BENEFITS TO PROVIDER / FINANCIAL AGREEMENT – I hereby request payment and assign any benefits due to me under the terms of any policy or policies and/or under Title XVIII of the Social Security Act that may cover professional services rendered to the above-named assignee. I agree to pay all co-pays and co-insurance at the time of service, along with any balance of the charges over and above the above-mentioned benefits. It is understood the undersigned is financially responsible for charges not covered by this assignment.

FREEDOM OF CHOICE – In the coordination of care, arrangement or referral may be made to services or at facilities which may be out-of-network with my insurance plan or which the provider or clinic has ownership interest. I understand that I have a choice as to where to obtain recommended health care services.

AUTHORIZATION TO RELEASE INFORMATION – I authorize the release of any information to any insurance company or third-party payor for the purpose of obtaining payment for services provided. I authorize the release of any information to any physician, skilled facility or other medical or health care provider as necessary for my care.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES – I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

MEDIA CONSENT – I authorize and hold harmless for the clinic to take, use, and disclose photographs, audio, and videos for clinical, educational, research, quality control, or marketing purposes. Unless for patient medical records or with your permission, media will contain no patient identifier. ☐ Decline above. I authorize media for patient medical records only.

SIGNATURE *Firma* 簽名: _____ **DATE** *Fecha* 日期: _____

Patient or Responsible Party *Paciente o Persona Responsable* 患者或負責人

PRINT NAME *Nombre* 姓名: _____ **Relationship** *Relacion* 關係: _____