

Date: \_\_\_\_\_

# PATIENT REGISTRATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Home phone ( \_\_\_\_\_ ) \_\_\_\_\_

\_\_\_\_\_ Work phone ( \_\_\_\_\_ ) \_\_\_\_\_

Employer \_\_\_\_\_ How Long? \_\_\_\_\_ Cell phone ( \_\_\_\_\_ ) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Driver's License Number \_\_\_\_\_ State \_\_\_\_\_

Spouse \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

### In Case of Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_ Work phone ( \_\_\_\_\_ ) \_\_\_\_\_

### Nearest Relative Not Living With You:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_ Work phone ( \_\_\_\_\_ ) \_\_\_\_\_

### Insurance Information:

\_\_\_\_\_ Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ Private \_\_\_\_\_ Other \_\_\_\_\_ None

Name of Insurance Company \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_

Individual or Thru Employer? \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Insured DOB \_\_\_\_\_ Insured SSN \_\_\_\_\_

### Other Insurance Information:

\_\_\_\_\_ Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ Private \_\_\_\_\_ Other \_\_\_\_\_ None

Name of Insurance Company \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_

Individual or Thru Employer? \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Insured DOB \_\_\_\_\_ Insured SSN \_\_\_\_\_

### Referring Doctor Information:

How did you find out about our practice? \_\_\_\_\_

Referring Doctor \_\_\_\_\_

Family Doctor (if dif ferent from above) \_\_\_\_\_

### ASSIGNMENT OF BENEFITS

I hereby assign to Dr. Royal H. Benson, III such insurance benefits to which are entitled under my insurance plan(s)

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

### MEDICARE LIFETIME SIGNATURE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Royal H. Benson, III for any services furnished me by the physician. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

### CONSENT FOR TREATMENT

I hereby authorize Dr. Royal H. Benson, III to examine, treat and perform diagnostic tests and office procedures that he deems necessary.

I am 18 years or older and authorize release of this information to my parents.

Yes  No  No restrictions  Restrictions \_\_\_\_\_

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

#### NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners  
Attn: Investigations  
1812 Centre Creek Drive, Suite 300  
P.O. box 149134  
Austin, Texas 78714-9134

Assistance in filing a complaint is available by calling the following telephone number:  
1-800-201-9353.

#### AVISO SOBRE QUEJAS

Se pueden presentar quejas acerca de medicos, asi tambien como de otras personas autorizadas y registradas por la Junta de Examinadores Medicos del Estado de Texas (Texas State Board of Medical Examiners), incluyendo a ayudantes medicos y acupunturistas, para su investigacion, en las siguiente direccion:

Texas State Board of Medical Examiners  
Attn: Investigations  
1812 Centre Creek Drive, Suite 300  
P.O. box 149134  
Austin, Texas 78714-9134

Se puede obtener ayuda para presentar una queja llamando al siguiente numero telefonico:  
1-800-201-9353.

# PATIENT'S HISTORY

Marital Status \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

Significant hobbies/sports \_\_\_\_\_

If you are a student, what is your field of study? \_\_\_\_\_

## Past Obstetric History Pregnancies (including miscarriages and abortions)

Number	Year	Months at Delivery	Infant Size	Living?	Labor Length	Complications?
1						
2						
3						
4						
5						

History of Abnormal PAP Smears \_\_\_\_\_

Major on-going non-gynecological problems \_\_\_\_\_

Describe Hospitalizations and Surgeries other than those relating to information above:

\_\_\_\_ Year Reason \_\_\_\_\_

\_\_\_\_ Year Reason \_\_\_\_\_

\_\_\_\_ Year Reason \_\_\_\_\_

\_\_\_\_ Year Reason \_\_\_\_\_

\_\_\_\_ Year Reason \_\_\_\_\_

\_\_\_\_ Year Reason \_\_\_\_\_

\_\_\_\_ Year Reason \_\_\_\_\_

Current Medicines \_\_\_\_\_

Drug Allergies \_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink alcohol?  Yes  No How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No

### FAMILY HISTORY

Relation	Alive?	Age now or age at death	Current Health Status	Cause of Death
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Children				
Children				
Children				
Children				

Do you have a family history of any of the following: \_\_\_\_\_

<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Spinal Cord Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Birth Defects
<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No Mental Retardation
<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No Downs Syndrome
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Other
<input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Disease	Birth Related Disorders _____