CelebrityCare
MEDICAL CLINIC

37131 IH 10, Suite 101, Boerne, TX 78006
830-249-8400 Office 830-255-4660 Fax

PATIENT REGISTRATION FORM

Today's Date: _____ _____ New Patient _____ Updated Information

Patient Legal Name: _____ Age:_____ Date of Birth: _____
Last First Middle

Address: _____
Street or PO Box City State Zip Code

Hm. Phone # _____ Mbl #_____ Other #_____

Email: _____

Marital Status: ( )Single ( )Married ( )Divorced ( )Widow ( )Other **Sex:** ( )Male ( )Female

Social Security #_____Driver's License # _____State_____

Employer/School:_____Occupation:_____Work #_____

Spouse/Parent's Name:_____Hm#_____Wk#_____

RESPONSIBLE PARTY: (If other than patient): Relationship to Patient:_____

_____
Name Address City State Zip code

_____ _____ _____ _____
Driver's License Number Home # Work # Employer Name and Number

_____ _____ _____
Occupation Social Security Number Date of Birth

LOCAL PERSON TO CONTACT IN CASE OF EMERGENCY:

Name:_____ Relationship to patient:_____ Phone No._____

Address:_____
Street or PO Box City State Zip Code

MEDICAL CARE: **I authorize CelebrityCare Inc. or designee to provide myself or my dependent with reasonable and proper medical care according to today's standards.**

Signature of Patient or Guarantor:_____ Date:_____