

# REGISTRATION

(PLEASE PRINT)

## WESTOVER HILLS CLINIC

11212 State Highway 151, Suite 190  
San Antonio, TX 78251  
Tel. (210) 523-9933 Fax (210) 647-0242

Date \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

### PATIENT INFORMATION

Name \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_ M \_\_\_ F AGE \_\_\_\_\_ Birthdate \_\_\_\_\_ Married \_\_\_ Widowed \_\_\_ Single \_\_\_ Divorced \_\_\_ Minor

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone ( ) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone ( ) \_\_\_\_\_

### PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

### ADDITIONAL INSURANCE

Is patient covered by additional insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Contact # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I have supplied correct information on this form and will notify staff of any changes. I authorize Westover Hills Clinic, PA through its personnel to render health care services to me in the form of examinations and treatments. I authorize Westover Hills Clinic, PA to disclose health care information to the above named insurance company for the purposes of obtaining payment for services rendered.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative Date

