Plano Supreme Primary Care
4020 Hedgcoxe Rd #700 Plano, TX 75024

Office: (972) 618-7800
Fax: (972) 618-7900

PATIENT REGISTRATION FORM

PATIENT INFORMATION: (Please use the full legal name, no nicknames)

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (Home):_____(Work):_____(Cell):_____

Birthdate: _____ Age: _____ Sex: M F No. of Children_____ Marital Status: M S W D

Social Security Number:_____ Employer: _____Occupation:_____

Email Address:_____

Referred By:_____ Person to Contact in Emergency:_____

Relationship:_____ Emergency Telephone:_____

GUARANTOR INFORMATION: If different from patient. (List person responsible for bill – use full legal name, no nicknames)

Relationship of Guarantor to Patient: Self__ Spouse __ Parent __ Other __

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone #: (_____) _____ Cell Phone #: (_____) _____

Date of Birth: _____ Sex: M F Social Security No.: _____

Employer: _____ Work #: (_____)_____Ext._____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE: Plan Name: _____

Policyholder's Name: _____ Insured Party: Self__ Spouse__ Parent__ Other__

Policy / ID #: _____ Policyholder's Date of Birth: _____

Policyholder's Social Security #: _____Group #: _____ Eff Date:_____

Claims Address: _____ Claims Telephone#:(_____)_____

SECONDARY INSURANCE: Plan Name: _____

Policyholder's Name: _____ Insured Party: Self__ Spouse__ Parent__ Other__

Policyholder's Social Security #: _____ Policyholder's Date of Birth: _____

Policy / ID #: _____ Group #: _____ Eff Date:_____

Claims Address & Phone: _____ Claims Telephone#:(_____)_____