TEXAS
INFECTIOUS DISEASE
INSTITUTE

# PATIENT REGISTRATION FORM

Patient Last Name | First Name | Middle Initial

Birthday | Age | Sex | Social Security Number

Street Address (Mailing Address) | Email Address

Home Phone Number | Work Phone Number

Race/Ethnicity | Religion | Language | Marital Status (S M D W)

Alternative Contact Name | Alternative Contact Phone | Relationship

Patient Employer | Employer Phone Number

Referring Physician Name | Primary Care Physician Name

Referring Physician Address | Primary Care Physician Address

Referring Physician City, State, Zip | Primary Care Physician City, State, Zip

Referring Physician Phone & Fax | Primary Care Physician Phone & Fax

Insurance Company | Group Number | Member ID

Policy Holder | Date of Birth | Relationship to Patient

Preferred Pharmacy | Phone Number

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me. I understand that I am financially responsible to pay any co-payment, deductible and coinsurance amounts not paid by my health plan for services received from Dr. Serge Lartchenko. I further understand that I am financially responsible for all charges, in the event I do not have health insurance coverage.

Patient Signature: _____ Date: _____

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