RGV Adult & Geriatric Medicine Specialist P.A.

208 Starr Street, Suite 3 Tel. (956) 903-4218 • Fax (956) 903-4149

Mercedes Children's Clinic

208 E. Starr Street Suite 2 • Mercedes, Texas 78570 Tel. (956) 514-1643

Patient's Registration

Full Name	LAST		FIRST		INITIAL
Date of Birth	(MONTH, DAY, YEAR	Age	Social S	ecurity #	
Father's Name (I	f patient is Under 21)				
Married	Single	_ Widow	Divorced	Separated_	-9 (1333)
YY A 1.1					
Home Address_	NUMBER	STREET	CITY	STATE	ZIP
Home Phone Number		ampleby ide	_ Cell Phone		10 36 1 7 Feb.
Patient's Occupa	tion		Employer		
					da i vo.
Spouse's Name			Ocupation		
Employer					
	gency Notify (Give Na			relative or Neighb	por)
In Case of Emer		ame, Address and	Celephone Number of		<u>'</u>
In Case of Emer	gency Notify (Give Na	ame, Address and	Celephone Number of		
In Case of Emer	gency Notify (Give National Section 1985) ble for Doctor's Bill:	ame, Address and	Celephone Number of owledge that in the e	vent my insurance	
In Case of Emer	gency Notify (Give Na	ame, Address and	Celephone Number of owledge that in the e	vent my insurance	
Person Responsi Iassociated wit	gency Notify (Give National Section 1985) ble for Doctor's Bill:	acknownt, I will be respon	owledge that in the ensible for all services	vent my insurance rendered.	e rejects any fe
Person Responsi Iassociated wit	ble for Doctor's Bill: Please Print) h my visit or treatme	acknownt, I will be respon	owledge that in the ensible for all services & Medicaid, please j	vent my insurance rendered.	e rejects any fe
Person Responsi I associated wit INSURANCE IN	ble for Doctor's Bill: Please Print) h my visit or treatme	acknownt, I will be respon	owledge that in the ensible for all services & Medicaid, please to the medicaid of the medicaid.	vent my insurance rendered. fill in the numbers CARE	e rejects any fe
Person Responsi Iassociated wit INSURANCE IN Other Insurance:	ble for Doctor's Bill: Please Print) h my visit or treatment	acknownt, I will be respon	owledge that in the ensible for all services & Medicaid, please for MEDIC	vent my insurance rendered. fill in the numbers CARE	e rejects any fe
Person Responsi I associated wit INSURANCE IN Other Insurance: Group:	ble for Doctor's Bill: Please Print) h my visit or treatme	acknownt, I will be respon	owledge that in the ensible for all services & Medicaid, please to MEDIC	vent my insurance rendered. fill in the numbers CARE	e rejects any fe

PATIENT'S SIGNATURE
(If patient is a minor, Signature of the Father/Guardian)

10:	
(PATIENT NAME)	(DATE)
Hospital at Renaissance, referring you to Doctors co Rehab Hospital for treferral or have any que	an ownership or investment in Docto, LTD & Weslaco rehab Hospital. I at Hospital at Renaissance and/or Weslaceatment or testing. If you object to the estion about the notice, please let men to you as required by federal law and gulations.
Receipt acknowledge: _	
ricine to a second plan illigation	(PATIENT SIGNATURE)