Print Form

Mark D. Le M.D., P.A.
Medical Clinic

602B Lawrence Street Tomball, TX 77375
Tel: (281) 255-6333 Fax: (281) 255-6335

846 11th Street Hempstead, TX 77445
Tel: (979) 921-0647 Fax: (979) 921-0245

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Jr. ☐ Sr.	Marital status (check one) ☐ Single ☐ Mar ☐ Div ☐ Wid

Social Security no.:	DOB: MM/DD/YY	Sex: ☐ M ☐ F	Home phone no.:	Cell no.:

Address:	City:	State:	ZIP Code:

Employer:	Address:	Work phone no.:

Chose clinic because or referred to clinic by:	

To register to log into your **Patient Portal** account, please provide your email address:	

INSURANCE & BILLING INFORMATION

GUARANTOR INFORMATION (Person responsible for the bill): ☐ Check here if Guarantor is Self

Name of Guarantor:	DOB: MM/DD/YY	Address (if different):	Home phone no.:

Is this person a patient here? ☐ Yes ☐ No

Employer:	Employer address:	Employer phone no.:

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance:	Name of Subscriber: ☐ Subscriber is Self	DOB: MM/DD/YY	Sex: ☐ M ☐ F

Policy no.:	Group no.:

Patient's relationship to Subscriber:	☐ Spouse	☐ Child	☐ Other:

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance:	Name of Subscriber: ☐ Subscriber is Self	DOB: MM/DD/YY	Sex: ☐ M ☐ F

Policy no.:	Group no.:

Patient's relationship to Subscriber:	☐ Spouse	☐ Child	☐ Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mark D. Le M.D.,P.A. to release any information required to process my claims.

Patient/Guardian Signature _____ Relationship _____ Date _____