Collin County Surgeons
4510 Medical Center Drive, Suite 214
McKinney, Texas 75069

(214)592-9200 Offc
(214)726-0079 Fax

Registration Form

Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to look over this information from time to time to make sure it stays up-to-date.

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Sex ☐M ☐F Age _____ Birthdate _____

Patient employer/school _____

Employer/School address _____

_____

SS# _____-_____-_____

☐ Single ☐ Married

☐ Separated ☐ Divorced

Occupation _____

Home Phone (_____)_____-_____

Work Phone (_____)_____-_____

Cell Phone (_____)_____-_____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone (_____)_____-_____

PRIMARY INSURANCE

Person responsible for account _____

Relation to patient _____ Birthdate _____

Address (if different from Patient's) _____

City _____ State _____ Zip _____

Person responsible employed by _____

Insurance Company _____

SS# _____-_____-_____

Phone (_____)_____-_____

Group ID _____

Subscriber ID _____

ADDITIONAL INSURANCE

Is the Patient covered by additional insurance? ☐Y ☐N

Subscriber name _____Birthdate _____

Address (if different from Patient's) _____

City _____ State _____ Zip _____

Subscriber employed by _____

Insurance Company _____

Relation to Patient _____

SS# _____-_____-_____

Phone (_____)_____-_____

Group ID _____

Subscriber ID _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Collin County Surgeons all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative — Date

_____ _____
Please print name of Patient, Guardian, or Personal Representative — Relationship to Patient