

REGISTRATION (Please Print)

PEDRO E. ESTORQUE JR., M.D., P.A.

2625 SCRIPTURE STREET, SUITE 103, DENTON, TX. 76201 • TELEPHONE: 940 320-0506 • FAX: 940 320-0506

Date: _____ Home Phone: _____ Cell Phone: _____

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SEX: MALE FEMALE AGE: _____ BIRTHDATE: _____

MARRIED SINGLE MINOR WIDOWED SEPARATED DIVORCED PARTNERED FOR _____ YRS.

RACE: AMERICAN INDIAN OR ALASKAN NATIVE ASIAN BLACK CAUCASIAN OTHER
 PACIFIC ISLANDER DECLINED

PRIMARY LANGUAGE: _____ ETHNICITY: NON-HISPANIC HISPANIC DECLINED

PATIENT EMPLOYER/SCHOOL: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF EMERGENCY, NOTIFY? _____ PHONE: _____

PRIMARY INSURANCE

SUBSCRIBER INFORMATION:

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

RELATIONSHIP TO PATIENT: _____ BIRTHDATE: _____ SS#: _____

ADDRESS (IF DIFFERENT FROM PATIENT'S): _____

PHONE: (____) _____ PERSON RESPONSIBLE EMPLOYED BY: _____

EMPLOYER'S ADDRESS: _____

CITY _____ ST. _____ ZIP _____

INSURANCE COMPANY: _____

SUBSCRIBER ID #: _____ GROUP #: _____

SECONDARY INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? Yes NO IF YES, RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S NAME: _____ BIRTHDATE: _____

INS. CO. NAME: _____ SUBSCRIBER ID #: _____ GROUP#: _____

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH _____
(YOUR INSURANCE CO.)

AND ASSIGN DIRECTLY TO DR. ESTORQUE 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 MY 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.

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

PLEASE PRINT NAME

RELATIONSHIP TO PATIENT