

HealthSource of Houston

ENTRANCE APPLICATION

WELCOME! ... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION. PLEASE FILL OUT THE INFORMATION BELOW, SO THAT WE CAN FILE YOUR INSURANCE FOR YOU. IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK

THANK YOU!

First Name _____ Middle _____ Last _____

DOB: ____/____/____ Age _____ Marital Status: S M W D Gender: Male Female

Address _____

City _____ State _____ Zip _____

Home Phone: _____ Cell: _____ Work: _____

Social Security Number ____ - ____ - ____ E-mail Address _____

Employer _____ Job Title _____

How did you hear about us? _____

INSURANCE INFORMATION

Insurance Company: _____

Subscriber's Name: _____ Relationship to Patient: _____

Social Security Number ____ - ____ - ____ D.O.B _____

Member ID #: _____ Group #: _____

Name of their employer _____ City _____

Employer Phone _____

Children--Names & Ages _____

In case of emergency, whom should we contact? _____

Relationship to you? _____ Phone Number: _____

FAMILY PHYSICIAN _____

What is your primary complaint? _____

IS THIS WORKMAN'S COMPENSATION? _____ IS THIS AN AUTO ACCIDENT? _____

(Office use only)

Account Number: HOU _____ Date: _____