RGV Adult & Geriatric Medicine Specialists P.A.
902 S. Airport Dr., Suite 4 - Weslaco, Texas 78596.
Tel. (956) 969-8877 • Fax (956) 969-8377
1010 S. James St. Ste B • (956) 968-1621, Weslaco, TX 78596

Mercedes Children's Clinic
208 E. Starr St. Mercedes, Texas 78570
Phone: (956) 514-1643

Patient's Registration

Full Name _____
LAST FIRST INITIAL

Date of Birth _____ Age _____ Social Security No. _____
(MONTH, DAY, YEAR)

Father's Name *(If Patient is Under 21)* _____

Married _____ Single _____ Widow _____ Divorced _____ Separated _____

Home Address _____
NUMBER STREET CITY STATE ZIP

Home Phone Number _____ Business Phone Number _____

Patient's Occupation _____ Employer _____

Spouse's Name _____ Occupation _____

Employer _____

In Case of Emergency Notify (*Give Name, Address and Telephone Number of Relative or Neighbor*)

_____

Person Responsible for Doctor's Bill _____

I _____ acknowledge that in the event my insurance rejects any fees
(Please Print)
associated with my visit or treatment, I will be responsible for all services rendered.

INSURANCE INFORMATION (*If Patient has Medicare & Medicaid, please fill in the numbers from the cards*)

Other Insurance _____ MEDICARE _____

Group _____ MEDICAID _____

Policy Number _____

Policy Number _____

Policy Number _____

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

To: _____ _____

(PATIENT NAME) (DATE)

I, or my colleagues, own an ownership or investment in Doctors Hospital at Renaissance, LTD & Weslaco Rehab Hospital. I am referring you to Doctors Hospital at Renaissance and/or Weslaco Rehab Hospital for treatment or testing. If you object to the referral or have any questions about the notice, please let me know. This notice is given to you as required by federal law and the clinic's rules and regulations.

Receipt acknowledged: _____

(PATIENT SIGNATURE)