UT MEDICINE SAN ANTONIO
UT HEALTH SCIENCE CENTER™
WE MAKE LIVES BETTER

New Patient Information

PATIENT INFORMATION

Last Name | First Name | Middle Name | Suffix (Jr, Sr, etc.) | Title (Mr., Mrs., Ms, Dr) | Sex (Circle) M / F

Date of Birth | Social Security Number | Alias or Nickname (Last, First, Middle) | Marital Status

Permanent Address | City | State | Zip | County | Country

Home Phone | Work Phone | Cell Phone | Other

Which phone number would you like to use as your primary contact? _____

Temporary Address | City | State | Zip | County | Country

For Temporary Address, please provide: Start Date: _____ Stop Date: _____

REFERRING PHYSICIAN AND PRIMARY CARE PROVIDER (PCP) INFORMATION

What provider referred you to our clinic today? _____
Name (Last, first) | Address | Phone#

Name of **PCP** (Last, First) | Address | Office Phone #

EMPLOYMENT INFORMATION

Name of Employer | Employer Phone Number | Employer Address (Street, City, Zip Code)

Occupation | Employment Status (part-time, full-time)

EMERGENCY CONTACT INFORMATION

1. _____
Name (Last, First, Middle) | Relationship to Patient | Telephone (Home, Work, Cell)

2. _____
Name (Last, First, Middle) | Relationship to Patient | Telephone (Home, Work, Cell)

GUARANTOR (If self, please skip to insurance section)

Relationship to Patient | Last Name | First Name | Middle Name | Sex (circle)

Social Security Number | Date of Birth | Home Phone | Work Phone

Permanent Address | City | State | Zip | County | Country

Name of Employer | Employer Phone Number | Employer Address (Street, City, Zip Code)

Occupation | Employment Status (Part-time, Full-time)

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PRIMARY INSURANCE

_____ Subscriber for the Coverage? ☐ Self ☐ Other _____
Name of Insurance

SUBSCRIBER INFORMATION (if self, please skip to Secondary Insurance)

Relationship to Patient | Last Name | First Name | Middle Name | Sex (Circle)

Social Security Number | Date of Birth | Home Phone | Work Phone

Permanent Address | City | State | Zip | County | Country

Name of Employer | Employer Phone Number | Employer Address (Street, City, Zip Code)

Occupation | Employment Status (Part-time, Full-time)

SECONDARY INSURANCE

_____ Subscriber for the Coverage? ☐ Self ☐ Other _____
Name of Insurance

SUBSCRIBER INFORMATION (if self, please skip to Secondary Insurance)

Relationship to Patient | Last Name | First Name | Middle Name | Sex (Circle)

Social Security Number | Date of Birth | Home Phone | Work Phone

Permanent Address | City | State | Zip | County | Country

Name of Employer | Employer Phone Number | Employer Address (Street, City, Zip Code)

Occupation | Employment Status (Part-time, Full-time)

IF THIRD INSURANCE, PLEASE LIST

Name of Insurance | Subscriber | DOB

Please be ready to provide:

1. ***Your insurance card(s)***
2. ***Your driver's license or ID***
3. ***Visit co-payment***