Betty Chung Grasty MD PA

NEW PATIENT REGISTRATION FORM

Patients Demographics

_____Male_____ Female Martial Status: _____

Name: _____ Date of Birth: _____/_____/_____

Address: _____ SSN: _____-_____-_____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____

What is the best time to reach you? _____What is the best number to call? _____

How did you hear about us? ____ Friend ____ Relative ____Doctor _____Other _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone _____ Cell Phone _____

Employment Information

Employer Name: _____ Work Phone: _____

Occupation: _____ Is it ok to contact you at this number? _____Yes _____ No

If yes, what is the best time to reach you? _____

Primary Insurance (PLEASE NOTIFY RECEPTIONIST OF ANY INSURNACE CHANGE)

Name of Insurance: _____ SSN of policy holder: _____-_____-_____

Subscriber Name: _____ Date of Birth: _____/_____/_____

Policy ID # _____ Group Number_____

Secondary Insurance

Name of Insurance: _____ SSN of policy holder: _____-_____-_____

Subscriber Name: _____ Date of Birth: _____/_____/_____

Policy ID # _____ Group Number_____

Pharmacy

Name of Pharmacy: _____ Phone: _____

Financial Policy

At our office it is our mission to provide the best possible medical care for our patients. In an effort to keep our fees affordable, we have adopted a no open billing policy. Payment is due at the time of service unless prior arrangements have been made. We accept cash, personal checks/debit cards, Visa and Master card. For patients with medical insurance, we will gladly accept assignment for your insurance benefits if you provide us with accurate information. We make every effort to closely estimate for you what your insurance coverage will be for your treatment. However, there are times when insurance underpays or denies payment on a claim for a variety of reasons. Any remaining balance not paid by the insurance within 60 days for any reason will become the responsibility of the patient or patient's responsible party. Your signature below indicates that you have read, understand, and agree to this policy.

Patient's Signature_____ Date _____/_____/_____

701 Tuscan Dr. Suite 235 Irving, TX 75039
Office Phone (972)409-0015 Fax (972)409-9858