RGV Diabetes, Endocrinology & Ambulatory Center

1001 Rone St. Suite A - Weslaco, Texas 78596. Tel. (956) 854-4084 • Fax (956) 969-8377 Mercedes Children's Clinic 208 E. Starr St. Mercedes, Texas 78570

Phone: (956) 514-1643

Patient's Registration

Full Name						
		LAST	FIR	ST	INITIAL	
Date of Birth _	<u></u>	ONTH, DAY, YEAR)	Age	Social Security No	0	
Father's Name		,				
Famer 8 Ivallie	(1) Palleni is Ona	er 21)				
Married	_ Single	Widow	Divorced	Separated	l	
Home Address	NUMBER	STREET	CITY	STATE	ZIP	
Home Phone N	umber		Business Pho	one Number		
Patient's Occupation Employer						
spouse's mame	Spouse's Name			Occupation		
Employer						
In Case of Eme	rgency Notify	(Give Name, Addi	ress and Telepho	one Number of Relative	e or Neighbor)	
Person Respons	sible for Docto	r's Bill				
Ι			acknowledge th	at in the event my insu	rance rejects any fees	
				at in the event my insu	funce rejects any rees	
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				MEDICADE		
Other msurance				_ WIEDICARE		
Group				MEDICAID		
Doliou Number						
Policy Number						
Policy Number						
Policy Number						

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)