THOMAS H. RAETZSCH, M.D.
PATIENT REGISTRATION FORM

Patient's Last name: _____ First name: _____

Preferred name: _____ Middle name: _____ Suffix: ❑ Jr ❑ Sr ❑ II ❑ III

Previous name (last, first) _____ Sex: ❑ M ❑ F DOB: _____ SSN: _____

Address: _____City: _____ State: ____ Zip: _____

Home phone: _____Mobile phone: _____ Consent to text: ❑ Yes ❑ No

Work phone: _____ Patient email: _____

GUARDIAN INFORMATION

Last Name: _____ First: _____ Middle name: _____

EMERGENCY CONTACT: ❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Friend ❑ Cousin ❑ Guardian ❑ Other

Name: _____Home phone: _____ Mobile phone: _____

NEXT OF KIN: ❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Friend ❑ Cousin ❑ Guardian ❑ Other

Name: _____ Home phone: _____

Would you like Patient Portal Access (online access to your information) : ❑ Yes ❑ No

Usual Provider: ❑ Thomas H. Raetzsch, M.D. ❑ Erin Fudge, APRN-C

Race: ❑ Black/African American ❑ White ❑ None

Ethnicity: ❑ None ❑ Hispanic or Latino/Spanish Language: ❑ English ❑ Spanish

Marital status: ❑ Single ❑ Married ❑ Single ❑ Divorcedv❑ Separated ❑ Widowed ❑ Partner

How did you hear about us? ❑ Advertising ❑ Primary Care Physician ❑ Specialist Physician ❑ Word of mouth

❑ Patient in the Practice ❑ Hospital ❑ Insurance Company ❑ Other: _____

How would you like to receive your patient summary report: ❑ Online portal ❑ Paper print out

I have read the following: ❑ Privacy Notice ❑ Release of Billing Information ❑ Assignments of Benefits

EMPLOYMENT

Employer Name: _____ Phone: _____

Usual Occupation: (Current or most recent) _____ Usual Industry: _____

INSURANCE

Primary Insurance:

Plan Name:_____ I.D. Number:_____ Group Number: _____

Address: _____ Phone number: _____

Secondary Insurance:

Plan Name:_____ I.D. Number:_____ Group Number: _____

Address: _____ Phone number: _____

GUARANTOR INFORMATION (Person responsible for bill)

Patient's relationship to Guarantor: ❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Friend ❑ Cousin ❑ Guardian ❑ Other

Last name: _____ First name: _____

Middle name: _____ Suffix: ❑ Jr ❑ Sr ❑ II ❑ III DOB: _____

(GUARANTOR INFORMATION Continued)

Mailing address: ❑ Same address as patient _____

City: _____ State: _____ Zip: _____

SSN: _____ Phone: _____

Email: _____ Employer: _____

IS YOUR VISIT DUE TO A JOB RELATED INJURY? ❑ Yes ❑ No

Date of Injury: _____ Place of injury/accident: _____

I hereby consent to treatment by the physicians and/or associates of Thomas H. Raetzsch, M.D.

Signature: _____ Date: _____

I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Thomas H. Raetzsch, M.D. I agree/consent to electronic disclosure of PHI. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

MEDICAL HISTORY

Date: _____

Patient's Name: _____ Birthdate: _____

Allergies to medicines: _____

_____

List all previous operations: _____

_____

_____

List all previous medical illnesses and hospitalizations: _____

_____

_____

Do you smoke? _____Yes _____ No How much alcohol do you drink? _____

Family History: List illnesses that run in your family

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Grandparents: _____

List all current medicines you are taking both over the counter and prescriptions:

_____

_____

_____

THOMAS H. RAETZSCH M.D.

1025 N. AUSTIN ST.
SEGUIN, TEXAS 78155
PHONE: 830-379-1184 FAX: 830-303-2314

ACKNOWLEDGEMENT OF THE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Date of Birth: _____

Social Security: _____

I acknowledge that Dr. Thomas H. Raetzsch Office has provided me with a written copy of the Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the information and ask questions.

I authorize Thomas H. Raetzsch Family Clinic to release health information to family member(s) or another individual or care giver(s) _____ Yes or _____ No

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

Patient's signature: _____

Date: _____

For Pre-Employment Physicals

I understand that my Employer will be receiving result of the physical exam and urine drug screen performed today. I also understand that Dr. Raetzsch is not my regular physician and will be performing only a pre-employment physical.

Patient's signature: _____

THOMAS H. RAETZSCH M.D.
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SEGUIN, TEXAS 78155
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FINANCIAL POLICY

We are committed to quality patient care in the most cost-effective manner possible. To ensure that our patients fully understand our billing process, we ask that you read and sign the financial policy statement.

PATIENT RESPONSIBILITY:

It is the responsibility of the patient to pay his/her co-payment and any unpaid portion of the deductible at the time of service. For patients without insurance coverage, payment is due at the time of service.

PAYMENT OPTIONS:

For your convenience we accept Cash, Check, Visa and Mastercard

MINORS:

A minor must be accompanied by a guarantor for his or her account (the parent or guardian of the minor or other adult accompanying the minor during each visit).

INSURANCE:

The physician will bill insurance plans if the patient provides the required insurance information and signs an assignment of benefits.

PAYMENT ARRANGEMENTS:

Prior payment arrangements must be made if a patient is unable to make full payment of the patient balance when due.

I have read, understand and agree to accept the office financial policies described above.

_____ _____

Signature of patient or responsible party Date