Jeffrey A. George, M.D.
Board Certified • Family Medicine

972-548-1717
Fax 972-548-9190
5236 W. University Dr. Suite 3200
McKinney, TX 75071
familydoctorofmckinney.com

PATIENT YEARLY REGISTRATION FORM

Patient's Legal Last Name:	**Legal First Name:**	**Middle:**
Patient's Preferred Name:		**Marital Status**:

Email Address:	**Social Security #:**	**Birth Date:**	**Age:**	**Sex:**

Home Phone:	**Work Phone:**	**Cell Phone:**	**Preferred Contact:**

Mailing Address:	**City:**	**State:**	**Zip Code:**

Referred to Clinic By: (please check one box):
☐ Family ☐ Friend ☐ Close to home/work
☐ Yellow Pages ☐ Web Site ☐ Insurance Plan ☐ Hospital
☐ Dr. _____ ☐ Other_____

Family Members seen by Dr. Brinkman, DeShazo or George:
_____
_____

PAYMENT & INSURANCE INFORMATION *Please present your insurance card to the receptionist at each visit*

Person Responsible for Bill: ***(if different than patient)***	Social Security #:	Birth Date:
Is this person a patient here? ☐ Yes ☐ No Is this person insured? ☐ Yes ☐ No	Home Phone:	Cell or Work Phone:

Patient's Relationship to this person: ☐ Spouse ☐ Child ☐ Other

Mailing Address: (*if different than patient*)	City:	State:	Zip Code:

PRIMARY Insurance:	Group #:	Policy #:	Co-Payment:	Effective Dates: to

Subscriber's Name: *(if different than patient)*	Subscriber's S.S. #:	Subscriber's Birth Date:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY Insurance:	Group #:	Policy #:	Co-Payment:	Effective Dates: to

Subscriber's Name: *(if different than patient)*	Subscriber's S.S. #:	Subscriber's Birth Date:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

CONTACT IN CASE OF EMERGENCY

Name:	Home Phone:
Relationship to Patient:	Cell or Work Phone:

The above is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Jeffrey A. George, M.D. or insurance company to release any information required to process my claims.

_____ _____

Patient or Guardian Signature **Date**