Agave Family
Physician, PLLC

Welcome to Our Practice

Patient Registration

Patient Name: _____ Maiden Name: _____

Date of Birth: _____ Social Security #: _____ Sex: _____

Race:_____ Ethnicity:_____Preferred Language:_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____ Employer/School: _____

How did you hear about our practice? _____

Please complete the following information for patients under the age of 18

Name of Responsible Party: _____ Relationship To Patient: _____

Date of Birth: _____ Social Security #: _____ Sex: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

School (if student): _____ Employer: _____

Primary Insurance Information

Insurance Company: _____ Name Of Insured: _____

Claims PO Box Address: _____

Date of Birth: _____ Social Security #: _____

Policy #: _____ Group #: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance Information

Insurance Company: _____ Name Of Insured: _____

Claims PO Box Address: _____

Date of Birth: _____ Social Security #: _____

Policy #: _____ Group #: _____

Relationship to Patient: _____ Employer: _____

Preferred Pharmacy_____ Phone Number: _____

Address or Cross Streets: _____

I/We hereby state that the information above is true and correct to the best of my/our knowledge.

_____ _____

Signature of Patient/Guarantor Date

(v1.19)