Texas Lipid Clinic

3205 W. Davis Suite B222
Conroe, TX 770304

Patient Registration Form (please print clearly)

Patient's Name: _____ ***Birthdate:*** _____ ***Age:***____ ***Sex: M F***
Address: _____ ***City:*** _____ ***Zip:*** _____
Home Phone: _____
Social Security No: _____ ***Driver's License:*** _____
Patient's Employer:_____ ***Work Phone:***_____

Are you covered by Medicare ? _____ ***Are you covered by Medicaid?***_____

Guarantor (Insured Person): _____ Date of Birth:_____
Work Phone of Guarantor:_____

Primary Insurance Carrier: _____ Secondary Carrier:_____
Group #_____ Group #_____
Identification#_____ Identification#_____

Relationship of Patient to Insured:
___Self ___Spouse ___Child ___Other

Relationship of Patient to Insured:
___Self ___Spouse ___Child ___Other

In case of **Emergency** contact: _____ Relationship:_____
Telephone # _____

Pharmacy: _____ Your email:_____

How did you hear about us ?
Insurance Plan: ___ Phone Book: ___ Patient/Friend:___ Newspaper:___ Mail___ Website___

*I hereby authorize **Texas Lipid Clinic** to furnish information to insurance carriers and parties/vendors directly involved concerning my illness and/or treatments. I hereby assign to **Texas Lipid Clinic** all payment for medical services rendered to myself or my dependents. Furthermore, I give consent to be treated by the physicians/staff at **Texas Lipid Clinic**.*

***Texas Lipid Clinic** is a specialty clinic which provides each patient with a customized diagnostic and treatment plan. Not all testing may be covered by insurance plans. Dr. Pieniazek will order tests that he determines are necessary to provide the highest standard of care based on the current literature in the field of lipidology and heart attack/stroke prevention. The cost for lab and/or diagnostics not covered by insurance will be collected directly from the patient / guardian.*

Signature: _____ Date: _____