

**PLASTIC SURGERY ARTS CENTER**  
**JAN GARCIA, JR., M.D., P.A.**  
**333 N. TEXAS AVENUE SUITE 2200**  
**WEBSTER, TX 77598**  
**281-338-2766/FAX# 281-338-1476**

REGISTRATION

DATE: \_\_\_\_\_

**PATIENT INFORMATION**

NAME: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Hm.Ph# \_\_\_\_\_ Cell Ph# \_\_\_\_\_ Work Ph# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female Marital Status: S M W D

Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address: \_\_\_\_\_

If Student F-time P-time ER Contact: \_\_\_\_\_ Phone# \_\_\_\_\_

Referred by: Yellow Pages Magazine Other: \_\_\_\_\_

**PRIMARY INSURANCE**

Insurance Type: PPO HMO CASH MEDICARE WORK.COMP. ATTORNEY

Person Responsible for Account: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address: (If different from patient's) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Hm.Ph# \_\_\_\_\_ Cell Ph# \_\_\_\_\_ Work Ph# \_\_\_\_\_

Responsible Party Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Resp. Party SS# \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Benefits Ph# \_\_\_\_\_ Subscriber/Policy# \_\_\_\_\_ Group# \_\_\_\_\_

NOTE: If Patient has Medicare as primary and has a secondary policy please provide ID card for a copy. We only file secondary insurance for Medicare patients.

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to JAN GARCIA, JR., M.D.P.A. all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my healthcare information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient/Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Parent/Guardian Printed Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_