

Patient Registration

Date: _____

Name: _____ Age: _____ Male _____ Female _____

Social Security #: _____ Date of Birth: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone #: _____

Insurance Co: _____ Ins Phone #: _____

Insured Name: _____

Insurance ID #: _____ Group #: _____

Employer: _____ Job: _____

Work Related Injury: ___ Yes ___ No Date of Injury: _____

Insured's or authorized person's signature: I authorize the physician to treat me and authorize payment of medical benefits to Mansfield Medical Clinic for services provided.

Signature _____ Date _____

You may fax or mail this form to the address below:

**Mansfield Medical Clinic
1720 El Broad St.
Mansfield, TX 76063
Fax: 817/453-2988**