☐ **Plaza Medical Centre**
700 N Pearl St, Suite N208
Dallas, TX 75201
Tel: (214) 999-9355

☐ **Griego Family Medical Centre**
2701 S Hampton Rd, Suite 101
Dallas, TX 75224
Tel: (214) 330-9221

PATIENT REGISTRATION

Patient Information

First Name	Last Name	MI	Date Of Birth __ __ / __ __ / __ __
Address	Apt. / City / State / Zip		
Phone Number	Home / Work / Cell		
Other Name(s) Used/Preferred	Email Address		
Gender ☐ Male ☐ Female	Social Security Number __ __ __ - __ __ - __ __ __ __	Driver's License	Employment Status

Marital Status
☐ Married
☐ Single
☐ Divorced
☐ Separated
☐ Widowed
☐ Life Partner

Preferred Contact
☐ Home Phone
☐ Work Phone
☐ Cell Phone
☐ Other _____

Preferred Language
☐ English
☐ Spanish
☐ Other _____

Race
☐ Native Indian / Alaskan
☐ Asian
☐ Black / African American
☐ White
☐ Hispanic / Latino
☐ Other _____

How did you hear about us?

Responsible Party (Guarantor) ☐ Same as Patient

First Name	Last Name	MI	Date Of Birth __ __ / __ __ / __ __
Address	Apt. / City / State / Zip		
Phone Number	Home / Work / Cell		
Social Security Number __ __ __ - __ __ - __ __ __ __	Relationship to Patient / Driver's License / Preferred Language		

Emergency Contact

First Name	Last Name	MI	Date Of Birth __ __ / __ __ / __ __
Address	Apt. / City / State / Zip		
Phone Number	Home / Work / Cell		

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the providers and staff of the Griego Family Medical Centre to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Griego Family Medical Centre to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

_____ **Signature of Patient/Responsible Party**

_____ **Date**

_____ **Name of Patient/Responsible Party (Print)**

_____ **Relationship to Patient**