SECTION # 1

Acct #:

Patient Name :

MACGREGOR MEDICAL CENTER
9969 FREDERICKSBURG RD
SAN ANTONIO, TX 78240-

PAT.BAL.

Appt Date:

Appt Time:

Reason:

SECTION # 2

PATIENT OR GUARDIAN FILL OUT SECTION # 2

RETURN TO FRONT DESK WITH ALL INSURANCE CARDS AND PHOTO ID.

VERIFY PATIENT INFORMATION — MAKE CHANGES BELOW

NAME:

ADDRESS:

CITY,STATE,ZIP :

HOME#

WORK#

SS#: DOB:

Primary Insurance:

Pol #: Grp #:

POLICY HOLDERS NAME: DOB: *REQUIRED*

Secondary Insurance

Pol #: Grp #:

POLICY HOLDERS NAME: DOB: *REQUIRED*

I HAVE VERIFIED AND MADE THE PROPER CHANGES. FAILURE TO PROVIDE CORRECT INFORMATION MAY RESULT IN FULL PATIENT RESPONISIBILITY FOR YOUR VISIT.

SIGNATURE F