AMCOT Austin
2525 South Lamar Blvd. Unit 12
Austin TX 78704
tel: (512) 647-1300
fax: (512) 647-13001
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PATIENT REGISTRATION FORM

Today's Date: ________________ _____ New Patient _____ Updated Information

Patient Legal Name: ____Age:_______ Date of Birth: _____________
Last First Middle

Address: ____
Street or PO Box City State Zip Code

Hm. Phone # _________________________ Mbl # _________________________ Other # _______________________

Email: ____

Marital Status: ( )Single ( )Married ( )Divorced ( )Widow ( )Other Sex: ( )Male ( )Female

Social Security #______________________________Driver's License # ____________________State_______________

Employer/School:_____________________________Occupation:________________________Work # _____________

Spouse/Parent's Name:____________________________Hm#________________Wk# ________________________

RESPONSIBLE PARTY: (If other than patient): Relationship to Patient:_______________________________________

____
Name Address City State Zip code

____
Home # Work # Occupation

LOCAL PERSON TO CONTACT IN CASE OF EMERGENCY:

Name:___________________________________ Relationship to patient:______________ Phone #: _________________

Address:____
Street or PO Box City State Zip Code

MEDICAL CARE: I authorize AMCOT Providers or designee to provide myself or my dependent with reasonable and proper medical care according to today's standards.

Signature of Patient or Guarantor:_____________________________________ Date:________________________