

Registration (please print)

**Leyka M. Barbosa, M.D.**

North Texas Joint Care, P. A.; 7777 Forest Lane, Suite C-610, Dallas, TX 75230

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: Male Y Female Y

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

MARITAL STATUS: Never Married Y Married Y Divorced Y Widowed Y Separated Y

OCCUPATION: Employer: \_\_\_\_\_ Profession: \_\_\_\_\_

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

Is your injury work related? Please circle: No (N) Yes (Y) (If yes, explain) \_\_\_\_\_

Referring Physician, or Primary Care Physician: \_\_\_\_\_

Reason For Your Visit: \_\_\_\_\_ Onset Date of Current Symptoms \_\_\_\_/\_\_\_\_/\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Insurance Information**

Primary Insurance \_\_\_\_\_ HMO PPO POS EPO OTHER

Insured's Name \_\_\_\_\_; Relationship To Patient: SELF SPOUSE DEPENDANT OTHER \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company Phone Number: (\_\_\_\_) \_\_\_\_\_; Insured's Employer & Benefits Address: \_\_\_\_\_

**Secondary Insurance Information**

Is There a Secondary Insurance? (If yes, what is it?) \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship To Patient: SELF SPOUSE DEPENDANT OTHER \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Secondary ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Ins. Company Phone Number:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_; Insured's Employer & Benefits Address: \_\_\_\_\_

**ASSIGNMENT AND RELEASE AND CONSENT TO CARE**

I, the undersigned, have insurance coverage with (Primary Ins.) \_\_\_\_\_, & (Secondary Ins.), \_\_\_\_\_, & (Tertiary Ins.) \_\_\_\_\_ and assign directly to Dr. Leyka Barbosa, (North Texas Joint Care, P. A.) all medical benefits and authority to appeal (for Pre-authorization denials, late/short/or non-payments) under ERISA or state jurisdiction, if any otherwise payable to me for services rendered. I understand that I am financially responsible for copays, deductibles, and any uninsured services. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I also hereby give my consent to the physician(s) of North Texas Joint Care, P.A. for medical treatment.

X \_\_\_\_\_  
SIGNATURE OF INSURED, GUARDIAN  
or AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE OF SIGNATURE