

**Teri Perryman, M.D., P.A.**

513 Granada Place  
Kerrville, Texas 78028  
(830) 896 - 2758

# Family Registration Form

(All Information is required)

## Name of Children Information

Patient's Full Name	Date of Birth:	Sex: (Circle One) M      F
Patient's Full Name	Date of Birth:	Sex: (Circle One) M      F
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Patient's Full Name	Date of Birth:	Sex: (Circle One) M      F
Patient's Full Name	Date of Birth:	Sex: (Circle One) M      F

## Mother / Guardian

Full Name		Date of Birth
Mailing Address	Physical Address (if different from mailing)	
Home Phone (      )	Social Security No.*	Drivers License No./State issued
Employer's Name and Address		
Name of Supervisor		Supervisor's Phone No.
Your Work Phone No.	Ext	Occupation
How Long Employed	Responsible Party's Relationship to Patient (please circle one) Mother    Grandmother    Aunt    Other :	

## Father /Guardian

Full Name		Date of Birth
Mailing Address	Physical Address (if different from mailing)	
Home Phone (      )	Social Security No.*	Drivers License No./State issued
Employer's Name and Address		
Name of Supervisor		Supervisor's Phone No.
Your Work Phone No.	Ext	Occupation
How Long Employed	Responsible Party's Relationship to Patient (please circle one) Father    Grandfather    Uncle    Other: _____	

\*If Social Security Numbers are not provided we reserve the right to require payment in full at the time of services are rendered.

**Other Information**

In Case of Emergency Notify	Phone No. (       )
Name of Nearest Friend/Relative Not Living With You	Phone No. (       )

**Insurance Information** \_\_\_\_\_ **Check here if copy of Ins Card provided**

Primary Insurance Carrier Address	
Insurance Carrier Phone Number	
Employer/Group Name	
Insured Name	Insured DOB
Policy I.D.	Group No.

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose or furnish full and complete insurance/Medicaid information for any and all plans to which I subscribe or derive a benefit from, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier. I understand that Teri Perryman, M.D., P.A. and Teri Perryman, M.D. do not accept retroactive insurance coverage. If I later become insured or Medicaid eligible Teri Perryman, M.D., P.A. and Teri Perryman, M.D. will not file claims for previously rendered services, but will accept such insurance or Medicaid coverage for future services.

I understand that Dr. Perryman reserves the right to request a Credit Report on the Guarantor of Account at any time. I understand that Dr. Perryman reports delinquent accounts to Credit Bureaus, which may affect my future ability to receive credit from other companies. I understand that such information reported to Credit Bureaus will remain on file for seven (7) years from the date of last reporting. I also understand that Dr. Perryman utilizes an outside collection agency for accounts outstanding greater than 120 days. If my account is placed with an outside agency all additional fees, costs or expense will be added to the placement amount. Such fee, costs and expenses include, but are not limited to, Collection Agency fees, Attorney Fees, and/or court cost.

I authorize the release of any medical or other information necessary to process claims for services rendered.

I authorize payment of benefits (private and governmental) directly to Teri Perryman, M.D., P.A. or Teri Perryman, M.D.

\_\_\_\_\_ **(initial)** I attest that I have provide a full disclosure of insurance/Medicaid coverage.

\_\_\_\_\_ **(initial, if applicable)** I attest and affirm that I have no secondary insurance in effect at this time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date