Lemon-AID
Medical Management

425 Holderrieth Blvd, Suite 114, Tomball, TX 77375
27933 Tomball Parkway, Tomball, TX 77375
Office 281.475.7599 Fax 833.973.3832

PATIENT REGISTRATION FORM

IDENTIFICATION

Last Name:	**First Name:**
Middle Initial:	**Previous Name:**
Date of Birth:	**Sex at Birth:** ☐ Male ☐ Female
Social Security #:	**Mother's Maiden Name:**

CONTACT INFORMATION

Street Address:	**Apt / Unit:**
City:	**State:**
Zip Code:	**County:**
Home Phone #:	**Mobile Phone #:**
Email:	**Preferred Contact:** ☐ Phone ☐ Email

EMERGENCY CONTACT

Name:	**Relationship:**
Phone #:	**Alternate Phone #:**

© 2026 Lemon-AID Medical Management. All rights reserved.

Lemon-AID
Medical Management

INSURANCE INFORMATION

Primary Carrier:	**Member ID:**
Group #:	**Policyholder Name:**
Policyholder DOB:	**Relationship to Patient:**
Secondary Carrier:	**Secondary Member ID:**

PHYSICIANS & PHARMACY

Primary Care Physician:	**PCP Phone #:**
Referring Physician:	**Referring Phone #:**
Preferred Pharmacy:	**Pharmacy Phone #:**
Pharmacy Address:	**Cross Street / Location:**

CURRENT MEDICATIONS

Include prescription, over-the-counter, vitamins, and supplements. Note dosage where known.

1.	**2.**	**3.**
4.	**5.**	**6.**
7.	**8.**	**9.**

MEDICATION ALLERGIES

List the medication and the reaction. Write "None known" if applicable.

1.	**2.**	**3.**
4.	**5.**	**6.**
7.	**8.**	**9.**

© 2026 Lemon-AID Medical Management. All rights reserved.

Lemon-AID
Medical Management

MEDICAL CONDITIONS

Include chronic conditions, prior surgeries, and ongoing treatment.

1.	**2.**	**3.**
4.	**5.**	**6.**
7.	**8.**	**9.**

ACKNOWLEDGMENT & SIGNATURE

I certify that the information provided above is accurate and complete to the best of my knowledge. I acknowledge that I have been offered a copy of this practice's Notice of Privacy Practices describing how my health information may be used and disclosed. I accept financial responsibility for services rendered that are not covered by my insurance, and I authorize this practice to release information required to process insurance claims.

Patient / Guardian Signature:	**Date:**
Printed Name:	**Relationship to Patient:**

For office use only: Chart # _____ Date entered _____ Staff initials _____

© 2026 Lemon-AID Medical Management. All rights reserved.