

TEXAS HEALTH CARE, P.L.L.C.

P.O. Box 961205
Fort Worth, Texas 76161-1205

PHYSICIAN: _____
BEING SEEN TODAY
LOCATION: _____ DATE: _____

Chart # _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ State: _____ Driver's License # _____
MM DD YY

Name: _____
LAST FIRST MI SEX DATE OF BIRTH AGE S M D W O
MARITAL STATUS

Address: _____
STREET (NO P.O. BOX'S PLEASE) APARTMENT CITY ST. ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____
STREET OR P.O. BOX CITY ST. ZIP

Occupation: _____ () WORK PHONE () EXT

Emergency Contact: (Please indicate a friend or relative not living at the same address.) () PATIENT'S ALT. PHONE (Cell, Mobile, etc.) () EXT

NAME PHONE RELATIONSHIP

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed

Patient Relationship to Responsible Party: Child _____ Other: _____
SPECIFY

Name: _____
LAST FIRST MI SEX DATE OF BIRTH AGE S M D W O
MARITAL STATUS

Address: _____
STREET (NO P.O. BOX'S PLEASE) APARTMENT CITY ST. ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____
STREET OR P.O. BOX CITY ST. ZIP

Occupation: _____ () WORK PHONE () EXT

OTHER PATIENT INFORMATION

Spouse Name: _____ Employer: _____
Spouse's Work Phone: () () EXT Occupation: _____

PRIMARY INSURANCE

Please provide copy of card to receptionist to attach to this form.

Insurance Company: _____ Address: _____
STREET OR P.O. BOX PHONE

Co-Pay Amount (if applicable) _____
CITY ST. ZIP

Primary Care Physician: _____

Policy Holder: _____
LAST FIRST MI SEX DATE OF BIRTH SS#

Patient Relationship to Insured Party: Self _____ Spouse _____ Child _____ Other _____
(SPECIFY)

Employer's Name: _____
INSURED ID GROUP NAME AND/OR NUMBER

Employer's Address: _____
STREET CITY ST ZIP

SECONDARY INSURANCE

Please provide copy of card to receptionist to attach to this form.

Insurance Company: _____ Address: _____ (____) _____
STREET OR P.O. BOX PHONE
Co-Pay Amount: (if applicable) _____ CITY ST. ZIP
Primary Care Physician: _____
Policy Holder: _____ MM DD YY
LAST FIRST MI SEX DATE OF BIRTH SS#
Patient Relationship to Insured Party: Self ___ Spouse ___ Child ___ Other _____
(SPECIFY)
Employer's Name: _____ INSURED ID GROUP NAME AND/OR NUMBER
Employer's Address: _____ STREET CITY ST ZIP

WORKMAN'S COMPENSATION

Workman's Compensation Insurance Name: _____ Adj _____
Address: _____ City: _____ State _____ Zip _____ Phone _____
Claim #: _____ DOI _____
What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other
Date of Accident _____ Have you reported the injury to your employer? ___Yes ___No When _____
Describe accident briefly: _____
Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____
Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ:

Texas Health Care, P.L.L.C. (THC), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that THC has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to THC, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company, or any balance due after payments by my Insurance Company.

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE