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

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

PHYSICIAN: _____
BEING SEEN TODAY

LOCATION: _____ DATE: _____

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 #: _____ Driver's License # _____ State: _____

Name: _____ ____ ____ ___/___/___ ____ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM DD YY) AGE MARITAL STATUS

Address: _____ _____ ____ _____ (____) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (____)_____ Day Phone: (____)_____ Email: _____

Race_____ Language_____ Ethnicity ❒ Hispanic/Latin ❒ Non Hispanic/Latin

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

Employer's Address: _____ _____ ____ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ _____ (____) _____
NAME RELATIONSHIP EMERGENCY CONTACT #

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 _____ Resp. Party SS #: _____
SPECIFY

Name: _____ ____ ____ ___/___/___ ____ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM DD YY) AGE MARITAL STATUS

Address: _____ _____ ____ _____ (____) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

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

Employer's Address: _____ _____ ____ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (____) _____ (____)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

Spouse's Work Phone: (____) _____ (_____) Occupation: _____
EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

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: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: _____ _____ _____ _____
STREET CITY ST ZIP

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

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: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker'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 this 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 it's 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/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances 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