

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