

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: _____
LAST FIRST MI SEX DATE OF BIRTH (MM / DD / YY) AGE S M D W O
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: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

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: _____
LAST FIRST MI SEX DATE OF BIRTH (MM / DD / YY) AGE S M D W O
MARITAL STATUS
Address: _____
MAILING ADDRESS 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: _____
MAILING ADDRESS CITY ST ZIP

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

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____
_____/_____/____ Spouse's Work Phone: (_____) (_____) Occupation: _____
DATE OF BIRTH 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