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 __/__/__ MM DD YY DATE OF BIRTH ____ 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
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)
Employer's Name: 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 ____________ SPECIFY Resp. Party SS #: ____________

Name: ____________ LAST ____________ FIRST ____ MI ____ SEX __/__/__ MM DD YY DATE OF BIRTH ____ AGE S M D W O MARITAL STATUS

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

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)
Employer's Name: 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: (____)____________(____) EXT Occupation: ____________

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