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 # ________________________

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

Address: ______________________________ ______________ ____ ______ (_____)______________
STREET (NO P.O. BOX's PLEASE) 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: ______________________________ ______________ ____ ______________
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: ____________________________________ _____ _____ ___/___/___ _____ S M D W O
LAST FIRST MI SEX DATE OF BIRTH AGE MARITAL STATUS

Address: ______________________________ ______________ ____ ______ (_____)______________
STREET (NO P.O. BOX's PLEASE) 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: ______________________________ ______________ ____ ______________
STREET OR P.O. BOX CITY ST. ZIP

Occupation: ______________________________ (______) __________________ (_____)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse Name: ______________________________ Employer: ______________________________

Spouse's Work Phone: (______) ______________(______) Occupation: ______________________________
EXT

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