

# 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: \_\_\_\_\_  
LAST FIRST MI SEX DATE OF BIRTH (MM / DD / YY) AGE MARITAL STATUS (S M D W O)

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

Emergency Contact: (Please indicate a friend or relative not living at the same address.) ( ) \_\_\_\_\_ ( )  
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 (MM / DD / YY) AGE MARITAL STATUS (S M D W O)

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: \_\_\_\_\_  
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

PCP: \_\_\_\_\_

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

Address: \_\_\_\_\_  
STREET CITY ST ZIP

## SECONDARY 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

## WORKMAN'S COMPENSATION

Workman'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 its 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