

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: _____
STREET or P.O. BOX 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.) () ALT PHONE (Cell, Mobile, et.c) () 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: _____
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: () () 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: _____
THC99P02 STREET CITY ST ZIP