**Please print and provide these forms to your physician at time of visit.**

Texas Health®

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# PATIENT REGISTRATION

Date: _____

## PATIENT DEMOGRAPHICS

Legal Name: _____
First MI Last Preferred Name

_____ DOB: _____ Mobile: _____
Parent/Legal Guardian Name

SS#: _____ DOB: _____ Legal Sex: ❑ Male ❑ Female

_____
Address Apt. # City State Zip

_____
Home Phone Work Phone Mobile Phone

Email: _____ ❑ No Email

Marital Status: ❑ Divorced ❑ Legally Separated ❑ Married ❑ Significant Other ❑ Single ❑ Widowed

Need Interpreter: ❑ Yes ❑ No Preferred Language: _____ Written Language: _____

Race: ❑ Asian ❑ Black ❑ Native American ❑ Native Hawaiian/Pacific Islander ❑ Two or More Races ❑ White

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

## PARENT / LEGAL GUARDIAN INFORMATION (IF APPLICABLE)

Parent/Legal Guardian Name _____ DOB _____ Mobile _____

## COMMUNICATION PREFERENCES

*By checking one of the boxes for Preferred Communication Method, I agree to receiving correspondence from Texas Health.*

Preferred Communication Method: ❑ No Preference ❑ Mail ❑ Phone ❑ Email ❑ MyChart ❑ Accept Text Messages

Do you have any communication difficulties/special needs?

Visually Impaired: ❑ Yes ❑ No Hearing Impaired: ❑ Yes ❑ No ❑ Special Needs: ❑ Yes ❑ No

If yes, please list: _____

## PRIMARY CARE PHYSICIAN (PCP)

Primary Care Physician: _____ ❑ No Primary Care Physician

## EMERGENCY CONTACT

_____
Name Relationship to Patient Home Phone Mobile Phone

## EMPLOYMENT

Employer Name: _____

Employment Status: ❑ Disabled ❑ Full Time ❑ Part Time ❑ Retired ❑ Student ❑ Unemployed

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**FOR OFFICE USE ONLY:**

Patient Name: _____

MRN: _____

## FINANCIALLY RESPONSIBLE PARTY – GUARANTOR

❑ Same as Patient Information (If different, please complete section below)

Name: _____
First MI Last Preferred Name

Relationship: ❑ Spouse ❑ Father ❑ Mother ❑ Other (please specify) _____

_____
Address Apt. # City State Zip

_____
Home Phone Work Phone Mobile Phone

Employer Name: _____

Employment status: ❑ Student ❑ Part Time ❑ Full Time ❑ Retires ❑ Disabled ❑ Unemployed

## INSURANCE INFORMATION

**Primary Insurance:** _____ ID: _____ Gp: _____

_____ Sex: ❑ M ❑ F _____
Subscriber Name Patient Relationship to Subscriber

_____ _____
Subscriber's DOB Employer

Employment Status: ❑ Disabled ❑ Full Time ❑ Part Time ❑ Retired ❑ Student ❑ Unemployed

**Secondary Insurance:** _____ ID: _____ Gp: _____

_____ Sex: ❑ M ❑ F _____
Subscriber Name Patient Relationship to Subscriber

_____ _____
Subscriber's DOB Employer

Employment Status: ❑ Disabled ❑ Full Time ❑ Part Time ❑ Retired ❑ Student ❑ Unemployed

## HOW YOU HEARD ABOUT US

❑ Family/Friend ❑ Email ❑ Newspaper/Magazine Ad ❑ Organizations Website
❑ Internet Search ❑ Television Commercial ❑ Organization Newsletter ❑ Other _____
❑ Referring Physician _____ ❑ Coach _____ ❑ Trainer _____

## ACKNOWLEDGMENT

I certify the information provided herein is complete and accurate. I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process. I understand that these collection attempts could be performed by from Texas Health Resources or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.

_____ _____ _____ _____
Patient or Legal Guardian Printed Name Patient or Legal Guardian Signature Date Time

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