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 _____

Parent/Legal Guardian Name _____

SS# _____ Mobile _____

DOB _____ Legal Sex ❑ M ❑ F

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____

Work _____ Mobile _____

E-Mail _____ ❑ 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 ❑ E-mail ❑ MyChart ❑ Accept Text Messages

Do you have any communication difficulties/special needs?

Visually Impaired : ❑ Y ❑ N Hearing Impaired: ❑ Y ❑ N Special Needs: ❑ Y ❑ N

If yes, please list _____

PRIMARY CARE PHYSICIAN (PCP)

Primary Care Physician _____ ❑ No Primary Care Physician

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FOR OFFICE USE ONLY:

Patient Name: _____
MRN: _____

EMERGENCY CONTACT

Name _____ Rel. to Patient _____
Home Phone _____ Mobile _____

EMPLOYMENT

Employer Name _____
Employment Status ❑ Disabled ❑ Full Time ❑ Part Time ❑ Retired ❑ Student ❑ Unemployed

FINANCIALLY RESPONSIBLE PARTY - GUARANTOR

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

First Name _____ MI _____
Last _____ Preferred Name _____

Relationship ❑ Spouse ❑ Father ❑ Mother ❑ Other (Please Specify) _____

_____

Address _____ Apt # _____
City _____ State _____ Zip _____
Phone _____
Work _____ Mobile _____
Employer Name _____
Employment Status ❑ Disabled ❑ Full Time ❑ Part Time ❑ Retired ❑ Student ❑ Unemployed

INSURANCE INFORMATION

PRIMARY INSURANCE _____

ID _____ Group # _____
Subscriber Name _____
Patient Relationship to Subscriber _____ Subscriber's DOB _____
Sex ❑ M ❑ F Employer _____
Employment Status ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

SECONDARY INSURANCE _____

ID _____ Group # _____
Subscriber Name _____
Patient Relationship to Subscriber _____ Subscriber's DOB _____
Sex ❑ M ❑ F Employer _____
Employment Status ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

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FOR OFFICE USE ONLY:

Patient Name: _____
MRN: _____

HOW YOU HEARD ABOUT US

❑ Family/Friend ❑ Email ❑ Newspaper/Magazine Ad ❑ Organization 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 Name _____

Signature _____ Date_____

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