Texas Health®

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

PKT-0767-NPELP 04/22 AC

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

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 ______________________