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: _____

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the Internet.

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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