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

Texas Health®

The attached forms will need to be printed and submitted at the time of your appointment.

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: ❑ N/A ❑ Low Vision ❑ Blind

Hearing Impaired: ❑ N/A ❑ Hard of Hearing ❑ Deaf Special Needs: ❑ Y ❑ N

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

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

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

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

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_____

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