

PATIENT REGISTRATION FORM

North Texas Orthopaedic Specialists
Tel: 214-820-7010 Fax: 214-820-7015

FOR OFFICE USE ONLY

Today's Date: _____

Acct # _____

Patient Information

| | | | | |
|---|--|---------------------|--|-------------------|
| Full Name: Last | | First | Middle | (Maiden) |
| Address: (Street or Box) | | City | State | Zip |
| Home Phone # () | Work Phone # () | Cell Phone # () | Email Address | |
| Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth | Age | Social Security # | Drivers License # |
| Occupation | Employer | Employer Address | | |
| Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated | | Spouse's Name | Race (check one) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other | |
| If Student, Indicate School | If Patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation required): | | | |
| Emergency Contact (not living at same address) | | | Emergency Contact Phone # () | |
| How did you hear about the physician you are seeing today? <input type="checkbox"/> Physician Referral (5) Who? _____ <input type="checkbox"/> Other Professional (6) <input type="checkbox"/> Existing Patient (10) <input type="checkbox"/> Family (8) <input type="checkbox"/> Friend (1) <input type="checkbox"/> Word of Mouth (9) <input type="checkbox"/> Baylor Hospital (19) <input type="checkbox"/> Health Plan/Insurance Company (17) <input type="checkbox"/> Emergency Room (7) <input type="checkbox"/> Direct Mail (18) <input type="checkbox"/> 1-800-4-BAYLOR Referral Line (3) <input type="checkbox"/> Website/Internet (13) <input type="checkbox"/> Walk-In (4) <input type="checkbox"/> Newspaper Advertisement (15) <input type="checkbox"/> Radio/TV (16) <input type="checkbox"/> Event (11) <input type="checkbox"/> Location (14) <input type="checkbox"/> Yellow Pages (2) <input type="checkbox"/> Unknown (20) | | | | |

Responsible Party

| | | | | |
|---------------------------|---------------------|--|-------------------|-----------------------------------|
| Guarantor Full Name: Last | | First | Middle | (Maiden) |
| Address: (Street or Box) | | City | State | Zip |
| Home Phone # () | Work Phone # () | Cell Phone # () | Drivers License # | |
| Date of Birth | Age | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Social Security # | Patient Relationship to Guarantor |
| Employer | | Employer Address | | |

Insurance Information

| | | | | | |
|--|--------------|---|--|--------------|---|
| Name of Primary Insurance Company | | Phone # () | Name of Secondary Insurance Company | | Phone # () |
| Mailing Address | | Mailing Address | | | |
| City | State | Zip | City | State | Zip |
| Policy Number | Group Number | Effective Dates of Policy From: To: | Policy Number | Group Number | Effective Dates of Policy From: To: |
| Policy Holder (if other than patient) | | Date of Birth | Policy Holder (if other than patient) | | Date of Birth |
| Social Security # | | Relationship to Patient | Social Security # | | Relationship to Patient |
| Policy Holder's Employer | | Work Phone # () | Policy Holder's Employer | | Work Phone # () |
| Employer Address | | | Employer Address | | |
| City | State | Zip | City | State | Zip |

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Patient Name: _____

Accident / Workers Comp

| | | |
|------------------------------------|--------------------------|--|
| Insurance Company | Phone # () | |
| Mailing Address | | |
| City | State | Zip |
| Effective Dates of Policy From: | Date of Accident / Onset | Due To: (circle one) Auto accident Work injury / illness |
| To: | | Other |
| Agent / Adjuster / Case Manager | | |
| If Workers Comp: Claim # | TWCC Claim # | |

Consent to Treat

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

If patient is a minor:
I consent for _____ to authorize evaluation and treatment for my child named
(Name(s): First & Last)
herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Signature of Patient, Parent, or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas (hereinafter "HT") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to HT. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HT, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Signature of Patient, Parent, or Legal Guardian **Date**