Fort Worth Hand Center

Texas Health Care, P.L.L.C

Please complete this form in its entirety at your first visit. It is the patient's responsibility to notify our office of any changes to the information listed on this form.

PATIENT REGISTRATION FORM

Patient Registration Information

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License #: _____ State: _____

First Name: _____ Last Name: _____ MI: _____ Sex: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Race: _____ Language: _____ Ethnicity: Hispanic/Latin _____ Non Hispanic/Latin _____

Employment Status (Circle): Full-Time Part-Time Retired Unemployed Student

Employer's Name or School: _____

Employer's Mailing Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____

Emergency Contact (Please indicate a friend or relative not living at the same address.)

Name: _____ Relationship: _____ Contact Number: _____

Other Patient Information

Spouse's Name: _____ Employer: _____

Date of Birth: _____ Spouse's Work Phone: _____ Occupation: _____

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Responsible Party and Billing Information

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child _____ Other (specify) _____

Responsible Party SS #: _____ First Name: _____ Last Name: _____ MI: _____

Sex: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Employment Status: _____

Employer's Name or School: _____

Employer's Mailing Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Work Phone: _____

Primary Insurance

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ Phone: _____

Co-Pay Amount: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Policy Holder Name (Last, First, MI): _____

Sex: _____ Date of Birth: _____ Social Security #: _____

Patient Relationship to Insured Party: Self _____ Spouse _____ Child _____ Other (Specify) _____

Employer's Name: _____ Insured ID: _____ Group Name/Number: _____

Address: _____ City: _____ State: _____ Zip: _____

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Secondary Insurance

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ Phone: _____

Co-Pay Amount: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Policy Holder Name (Last, First, MI): _____

Sex: _____ Date of Birth: _____ Social Security #: _____

Patient Relationship to Insured Party: Self _____ Spouse _____ Child _____ Other (Specify) _____

Employer's Name: _____ Insured ID: _____ Group Name/Number: _____

Workers Compensation

Workers Compensation Insurance Name: _____ Adj: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Claim #: _____

DOI: _____ What Employer: _____

Accident Information

Was this the result of an accident? Yes _____ No _____

Where did it occur? At Work _____ Auto Accident _____ Other _____

Date of Accident: _____ Have you reported this injury to you r employer? Yes _____ No _____ When? _____

Describe accident briefly: _____

_____

Do you have an attorney representing you? Yes _____ No _____ Who is the attorney? _____

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PATIENT REGISTRATION FORM

Referral Information

Who referred you? _____ Address: _____ Phone: _____

Family Physician: _____ Address: _____ Phone: _____

Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative

PLEASE READ

Texas Health Care, P.L.L.C. (THC), and it's physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgment that you have been advised that THC has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to THC, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint THC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____