

# TEXAS HEALTH CARE, P.L.L.C.

P.O. Box 961205  
Fort Worth, Texas 76161-1205

PHYSICIAN: Dr. Bradford  
BEING SEEN TODAY  
LOCATION: \_\_\_\_\_ DATE: \_\_\_\_\_

## 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: \_\_\_\_\_  
Name: \_\_\_\_\_  
LAST FIRST MI SEX DATE OF BIRTH (MM/DD/YY) AGE S M D W O MARITAL STATUS  
Address: \_\_\_\_\_  
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE  
Alt/Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Day Phone: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Race \_\_\_\_\_ Language \_\_\_\_\_ Ethnicity  Hispanic/Latin  Non Hispanic/Latin  
Full-Time Part-Time Retired Unemployed Student Employer's Name: \_\_\_\_\_  
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School  
Employer's Address: \_\_\_\_\_  
MAILING ADDRESS CITY ST ZIP  
Occupation: \_\_\_\_\_  
Emergency Contact: (Please indicate a friend or relative not living at the same address.)  
\_\_\_\_\_  
NAME RELATIONSHIP (\_\_\_\_\_) EMERGENCY CONTACT #

## 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 \_\_\_\_\_ Resp. Party SS #: \_\_\_\_\_  
SPECIFY  
Name: \_\_\_\_\_  
LAST FIRST MI SEX DATE OF BIRTH (MM/DD/YY) AGE S M D W O MARITAL STATUS  
Address: \_\_\_\_\_  
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE  
Full-Time Part-Time Retired Unemployed Student Employer's Name: \_\_\_\_\_  
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School  
Employer's Address: \_\_\_\_\_  
MAILING ADDRESS CITY ST ZIP  
Occupation: \_\_\_\_\_ (\_\_\_\_\_) WORK PHONE (\_\_\_\_\_) EXT

## OTHER PATIENT INFORMATION

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Spouse's Work Phone: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) Occupation: \_\_\_\_\_  
EXT

## PRIMARY INSURANCE

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

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
STREET or P.O. BOX PHONE  
Co-Pay Amount: (if applicable) \_\_\_\_\_  
CITY ST ZIP  
Primary Care Physician: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
LAST FIRST MI SEX DATE OF BIRTH SS #  
Patient Relationship to Insured Party: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_  
(SPECIFY)  
Employer's Name: \_\_\_\_\_  
INSUREDS ID GROUP NAME AND/OR NUMBER  
Address: \_\_\_\_\_  
STREET CITY ST ZIP

## SECONDARY INSURANCE

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

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) \_\_\_\_\_ CITY ST ZIP

Primary Care Physician: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ / / \_\_\_\_\_ SS #  
LAST FIRST MI SEX DATE OF BIRTH

Patient Relationship to Insured Party: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_\_\_  
(SPECIFY)

Employer's Name: \_\_\_\_\_ INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: \_\_\_\_\_ STREET CITY ST ZIP

## WORKER'S COMPENSATION

Worker's 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 your employer? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_

Describe accident briefly: \_\_\_\_\_

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

## 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 its 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 acknowledgement 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.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE