UTHealth East Texas Physicians

PATIENT REGISTRATION / INFORMATION

Name:______________________________ Birthdate:__________

Soc. Sec.#:______-______-______ Driver's License #:______________ Age:______ Sex: ☐ M ☐F

Address: ______________________________ Telephone: (____) __________

City, County, State, Zip: ______________________________ Marital Status: __________

Race Choices: ☐ White ☐ Asian ☐ Black ☐ Hispanic ☐ American Indian ☐ Other ☐ Unknown

Ethnic Choices: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

E-Mail Address: ______________________________ Cell Phone: (____) __________

Referring Physician:______________________________

Patients Employer: ______________________________

Address: ______________________________ Telephone: (____) __________

City, State, Zip:______________________________ Occupation: __________

Were you injured at work? ☐ Yes ☐ No If yes, how? ______________________________

SPOUSE / PARENT INFORMATION

Name:______________________________ Birthdate:__________

Soc. Sec.#:______-______-______ Sex: ☐ M ☐F

Address: ______________________________ Telephone: (____) __________

City, County, State, Zip: ______________________________ Marital Status: __________

Employer: ______________________________

Address: ______________________________ Telephone: (____) __________

City, State, Zip:______________________________ Occupation: __________

In Case of Emergency Contact:

Name:______________________________ Telephone: (____) __________

PRIMARY INSURANCE CARRIER

Company Name:______________ ID#:______________ Group#: __________

Member Name: ______________________________ Telephone: (____) __________

Address: ______________________________ City, State, Zip:______________

SECONDARY INSURANCE CARRIER

Company Name:______________ ID#:______________ Group#: __________

Member Name: ______________________________ Telephone: (____) __________

Address: ______________________________ City, State, Zip:______________

I hereby grant permission to UTHealth East Texas Physicians to employ such medical, surgical, and x-ray procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency, or its intermediary, any information needed for this or a related insurance claim. I agree to pay any charges incurred by me to UTHealth East Texas Physicians.

______________________________ ______________________________

SIGNATURE OF PATIENT (PARENT IF PATIENT IS A MINOR) DATE