



A Baylor-HealthTexas Affiliate

FOR OFFICE USE ONLY
Acct #

Today's Date: ___/___/_____

Referred By: Family Friend Insurance Co Internet Location/Drive by Emergency Room
 Baylor Direct Mail Billboard Physician referral other _____

Patient Information

Patients Full Name: Last		First		Middle		Preferred name	
Address:				City		State Zip	
Primary Contact Phone # () - <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> other			Secondary Contact Phone # () - <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> other			Alternate Phone# () - <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> other	
Date of Birth / /		Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security # / /		Drivers License #	
Occupation			Employer Address				
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Spouse's Name			Race <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:				
Emergency Contact (not living at same address)					Emergency Contact Phone # () -		

Responsible Party

Guarantor Full Name: Last		First		Middle		(Maiden)	
Address:				City		State Zip	
Primary Phone # () -		Secondary Phone # () -		Date of Birth. / /	Social Security # / /	Relationship to patient	
Employer			Employer Address				

Insurance Information

Primary Insurance Company			Phone # () -		Secondary Insurance Company			Phone # () -	
Claims Mailing Address					Claims Mailing Address				
City			State		Zip		City State Zip		
Policy Number		Group#	Effective Dates of Policy From: To:		Policy Number		Group#	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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CONSENT TO TREAT- FOR ALL PATIENTS

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.

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.

x

Signature of Patient, Parent, or Legal Guardian

Date

If patient is a minor:

I consent for _____ to authorize evaluation and treatment for my child named
Name of authorized person
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.

x

Signature of Patient, Parent, or Legal Guardian

Date

FINANCIAL RESPONSIBILITY- FOR ALL PATIENTS

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.

x

Signature of Patient, Parent, or Legal Guardian

Date