**TEXAS HEALTH CARE, P.L.L.C.**
P.O. Box 961205
Fort Worth, Texas 76161-1205

PHYSICIAN: ______________________
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) MM / DD / YY (DATE OF BIRTH) ____ (AGE) S M D W O (MARITAL STATUS)

Address: ______________ (MAILING ADDRESS) ______ (APARTMENT) ______ (CITY) ____ (ST) ____ (ZIP) ( ) ______ (HOME PHONE)

Alt/Cell Phone: ( ) ______________ Email Address: ______________

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)

Employer's Name: or School ______________

Employer's Address: ______________ (MAILING ADDRESS) ______ (CITY) ____ (ST) ____ (ZIP)

Occupation: ______________ ( ) ______ (WORK PHONE) ( ) (EXT)

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 ______________ (SPECIFY) Resp. Party SS #: ______________

Name: ______________ (LAST) ______________ (FIRST) ____ (MI) ____ (SEX) MM / DD / YY (DATE OF BIRTH) ____ (AGE) S M D W O (MARITAL STATUS)

Address: ______________ (MAILING ADDRESS) ______ (APARTMENT) ______ (CITY) ____ (ST) ____ (ZIP) ( ) ______ (HOME PHONE)

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE ONE)

Employer's Name: 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: ( ) ______________ ( ) (EXT) Occupation: ______________

## 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: ______________ ______ (INSURED ID) ______________ (GROUP NAME AND/OR NUMBER)

Address: ______________ ______ (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: ______________________ ______ ______ ____/____/____ ____________
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other ______________________ (SPECIFY)

Employer's Name: ______________________ ______________ ______________________
INSURED 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 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 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

# PHYSICIAN/PHARMACY INFORMATION

**Primary Care Physician**

Name: ______________________________

Address: ______________________________

______________________________

**FAX**: (    ) ______________ Phone: (    ) ______________

**Other Physicians**

Speciality: ______________

Name: ______________________________

Address: ______________________________

______________________________

**FAX**: (    ) ______________ Phone: (    ) ______________

Speciality: ______________

Name: ______________________________

Address: ______________________________

______________________________

**FAX**: (    ) ______________ Phone: (    ) ______________

**Pharmacy:** ______________ **Phone** (    ) ______________

Patient Name______________ Date__________

# HISTORY AND PHYSICAL

Age ____ Reason for consultation ________________________________________

For office use:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Medical Illnesses:** _____ None

Check any/all that apply:

| | | |
|---|---|---|
| ___Diabetes | ___Stroke | ___Hypothyroidism |
| ___Hypertension | ___Prolonged bleeding | ___Hyperthyroidism |
| ___Asthma/COPD | ___Reaction to anesthesia | ___Loose teeth/caps |
| ___History MI | ___GERD | ___Hepatitis/HIV |

Other/Explain ________________________________________________________

**Medications:** _____ None

______________________________mg Freq_________//____________

______________________________mg Freq_________//____________

______________________________mg Freq_________//____________

______________________________mg Freq_________//____________

______________________________mg Freq_________//____________

______________________________mg Freq_________//____________

Patient Name ________________________________________ Date______________

# HISTORY AND PHYSICAL

**Medication allergies/intolerances:** _____ None

________________________________ Reaction:__________________________

________________________________ Reaction:__________________________

Do you regularly use aspirin/ibuprofen: Yes/No Freq ______________________

**Surgical History:**

Procedure ____________________________________________________

Surgeon ________________________________ Date ________________

Procedure ____________________________________________________

Surgeon ________________________________ Date ________________

Procedure ____________________________________________________

Surgeon ________________________________ Date ________________

Procedure ____________________________________________________

Surgeon ________________________________ Date ________________

Procedure ____________________________________________________

Surgeon ________________________________ Date ________________

Procedure ____________________________________________________

Surgeon ________________________________ Date ________________

**Tobacco**: Yes/No If yes, _____ packs per day for _____ years

**If** not smoking, when did you quit? ________ years ago

**Alcohol:** Yes/No If yes, how much? ________________________

Patient Name ____________________________________ Date________________

# EMILY B. MCLAUGHLIN, M.D.

## Advance Directive

In the event that you are unable to communicate your desires for medical care, have you established an Advance Directive?

If so, would you have a copy forwarded to this office for your permanent record?

______ Yes, I have an Advance Directive.

______ No, I do not have an Advance Directive.

| Patient Name | Patient Signature | Date |
|---|---|---|

| Witness Name | Witness Signature | Date |
|---|---|---|

1200 W. MAGNOLIA AVE. SUITE 110 • FORT WORTH, TEXAS • 76104
PHONE: 817 870-4833 • FAX: 817 870-4893

# Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

________________________________________

Signature of Patient or Personal Representative

________________________________________

Print Name

________________________________________

Social Security #

________________________________________

Date

________________________________________

Name of Patient or Personal Representative

________________________________________

Description of Personal Representative's Authority