Highland GYNECOLOGY

Date: _____

PATIENT REGISTRATION

PATIENT DEMOGRAPHICS

Legal Name: _____

First MI Last Preferred

Name_____ DOB: _____ Mobile: _____

Parent/Legal Guardian Name

SS#: _____ DOB:_____ Legal Sex: □ Male □ Female

_____

Address Apt. # City State Zip

_____

Home Phone Work Phone Mobile Phone

Email:_____ □ No Email

Marital Status: □ Divorced □ Legally Separated □Married □ Significant Other □ Single □Widowed

Need Interpreter: □ Yes □ No

Preferred Language:_____ Written Language:_____

Race: □ Asian □Black □Native American □Native Hawaiian/Pacific Islander □Two or More Races □ White

Ethnicity: □ Hispanic □ Non-Hispanic

PARENT / LEGAL GUARDIAN INFORMATION (IF APPLICABLE)

Parent/Legal Guardian Name _____ DOB _____ Mobile_____

COMMUNICATION PREFERENCES

By checking one of the boxes for Preferred Communication Method, I agree to receiving correspondence from Texas Health.

Preferred Communication Method: □No Preference □ Mail □ Phone □ Email □MyChart □Accept Text Messages Do you have any communication difficulties/special needs?

Visually Impaired: □ Yes □ No Hearing Impaired: □Yes □ No □Special Needs: □Yes □ No

If yes, please list:_____

PRIMARY CARE PHYSICIAN (PCP)

Primary Care Physician:_____ □ No Primary Care Physician

EMERGENCY CONTACT

_____

Name Relationship to Patient Home Phone Mobile Phone

EMPLOYMENT

Employer Name:_____

Employment Status: □ Disabled □Full Time □ Part Time □ Retired □Student □Unemployed

FOR OFFICE USE ONLY:

Patient Name:_____

MRN:_____

FINANCIALLY RESPONSIBLE PARTY – GUARANTOR

□ Same as Patient Information (If different, please complete section below)

Name:_____

First MI Last Preferred Name

Relationship: □Spouse □ Father □ Mother □Other (please specify)_____

_____

Address Apt. # City State Zip

_____

Home Phone Work Phone Mobile Phone

Employer Name: _____

Employment status: □Student □ Part Time □Full Time □ Retires □Disable □Unemployed

INSURANCE INFORMATION

Primary Insurance:_____ ID:_____ Gp:_____

_____ Sex:□ M □ F _____

Subscriber Name Patient Relationship to Subscriber

_____ _____

Subscriber's DOB Employer

Employment Status: □ Disabled □ Full Time □Part Time □ Retired □ Student □ Unemployed

Secondary Insurance:_____ ID:_____ Gp:_____

_____ Sex: □M □F _____

Subscriber Name Patient Relationship to Subscriber

_____ _____

Subscriber's DOB Employer

Employment Status: □ Disabled □ Full Time □ Part Time □ Retired □Student □Unemployed

HOW YOU HEARD ABOUT US

□Family/Friend □ Email □Newspaper/Magazine Ad □Organizations Website

□ Internet Search ? Television Commercial □ Organization Newsletter □ Other _____

□ Referring Physician _____ □ Coach _____ □Trainer _____

ACKNOWLEDGMENT

I certify the information provided herein is complete and accurate. I hereby consent to credit bureau inquiries and to receiving

auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided

during my registration process. I understand that these collection attempts could be performed by from Texas Health Resources or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.

_____	_____	_____	_____
Patient or Legal Guardian Printed Name	Patient or Legal Guardian Signature	Date	Time