

**PATIENT REGISTRATION FORM**  
**Baylor Neurosurgery Associates**

FOR OFFICE USE ONLY

Acct # \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Patient Information**

Full Name: Last		First	Middle	(Maiden)
Address: (Street or Box)		City	State	Zip
Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )	Email Address	
Referred By:	Date of Birth	Age	Sex (circle one) Male Female	Social Security # Drivers License #
Occupation	Employer	Employer Address		
Marital Status (circle one) Single Married Widowed Divorced Separated	Spouse's Name		Race (circle one) American Indian Asian Black Hispanic White Other	
If Student, Indicate School		If Patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation required):		
Emergency Contact (not living at same address)			Emergency Contact Phone # ( )	

**Responsible Party**

Guarantor Full Name: Last		First	Middle	(Maiden)
Address: (Street or Box)		City	State	Zip
Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )	Drivers License #	
Date of Birth	Age	Sex (circle one) Male Female	Social Security #	Patient Relationship to Guarantor
Employer	Employer Address			

**Insurance Information**

Name of <b>Primary</b> Insurance Company <b>1.</b>		Phone # ( )	Name of <b>Secondary</b> Insurance Company <b>2.</b>		Phone # ( )
Mailing Address			Mailing Address		
City	State	Zip	City	State	Zip
Policy Number	Group Number	Effective Dates of Policy From: To:	Policy Number	Group Number	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

**(COMPLETE BACK OF FORM)**



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Acct # \_\_\_\_\_

Patient Name: \_\_\_\_\_

Accident / Workers Comp

Insurance Company	Phone # (     )	
Mailing Address		
City	State	Zip
Effective Dates of Policy	Date of Accident / Onset	Due To: (circle one)
From:		Auto accident    Work injury / illness
To:		Other
Agent / Adjuster / Case Manager		
If Workers Comp: Claim #	TWCC Claim #	

Consent to Treat

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.

I \_\_\_\_\_ authorize evaluation and treatment. I understand that this authorizes  
(Name(s): First & Last)  
the person(s) named above to consent to medical and surgical procedures and immunizations.

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.

**Signature of Patient**

**Date**

Financial Responsibility

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.

**Signature of Patient, Parent, or Legal Guardian**

**Date**

\_\_\_\_\_