

TURTLE CREEK SURGERY CENTER

PATIENT REGISTRATION

NAME _____ DATE _____

DOB _____ AGE _____ SEX (male) (female) MARTIAL STATUS (M) (S) (D)

SS# _____ DL# _____ E-MAIL ADDRESS _____

ADDRESS _____
(street) (city) (state) (zip code)

PHONE NO. _____
(home) (work) (cell) (other)

EMPLOYER _____
(name) (address) (phone no.)

PARENT/LEGAL GUARDIAN (if minor): _____ PHONE: _____

REFERRING DENTIST/PHYSICIAN _____

CONTACT PERSON NOT LIVING WITH YOU _____

ADDRESS _____ PHONE: _____

RESPONSIBLE PARTY'S SS# _____ DOB _____

WOULD YOU LIKE FOR US TO BILL YOUR INSURANCE? (YES) (NO)

PLEASE FURNISH INSURANCE CARDS FOR US TO COPY.

PRIMARY MEDICAL INSURANCE

INS. CO _____

ADDRESS _____

PHONE NO _____

GROUP NAME _____

GROUP NO. _____

INSURED'S NAME _____

RELATIONSHIP _____

INSURED'S EMPLOYER _____

PHONE# _____

PLAN# _____

SECONDARY MEDICAL INSURANCE

INS. CO _____

ADDRESS _____

PHONE NO _____

GROUP NAME _____

GROUP NO. _____

INSURED'S NAME _____

RELATIONSHIP _____

INSURED'S EMPLOYER _____

PHONE# _____

PLAN# _____

PATIENT'S SIGNATURE OR PARENT OR GUARDIAN'S SIGNATURE (if applicable)

(OVER)

I HEREBY AUTHORIZE DR. _____ TO PERFORM THE SERVICES THAT ARE NECESSARY IN HIS JUDGEMENT AND ANY ADDED PROCEDURES WHICH HE MAY DEEM NECESSARY FOR THE ABOVE PATIENT. I ALSO GIVE MY PERMISSION FOR DR. _____ AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS TO OBTAIN RADIOGRAPHS, PHOTOGRAPHS, AND OTHER RECORDS NECESSARY FOR TREATMENT. I UNDERSTAND THAT THESE RADIOGRAPHS, PHOTOGRAPHS, AND OTHER RECORDS REMAIN THE PROPERTY OF DR. _____ AND MAY BE USED FOR ANONYMOUS PUBLICATIONS.

I UNDERSTAND THAT TEXAS LAW PROVIDES, AND I AGREE, THAT IF ANY HEALTHCARE WORKER IS EXPOSED TO MY BLOOD OR ANY BODILY FLUID, TO ALLOW THE CLINIC TO PERFORM TEST(S) ON MY BLOOD OR OTHER BODILY FLUID TO DETERMINE THE PRESENCE OF ANY COMMUNICABLE DISEASE, INCLUDING, BUT NOT LIMITED TO, HEPATITIS, HUMAN IMMUNODEFICIENCY VIRUS (WHICH IS THE CAUSATIVE AGENT OF AIDS) AND SYPHILIS. I UNDERSTAND THAT SUCH TESTING IS NECESSARY TO PROTECT THOSE WHO WILL BE CARING FOR ME WHILE I AM A PATIENT OF THE CLINIC. I UNDERSTAND THAT THE RESULTS OF TESTS TAKEN UNDER THESE CIRCUMSTANCES DO NOT BECOME A PART OF MY MEDICAL RECORDS.

_____ I HAVE ADVANCE DIRECTIVES.

_____ I DO NOT HAVE ADVANCE DIRECTIVES.

(IF YES, PLEASE PROVIDE A COPY OF THE DOCUMENT)

PATIENT'S SIGNATURE OR PARENT OR GUARDIAN'S SIGNATURE (if applicable)