

**Registration**

**UT Health Services**

**Date:**  
**Update:**  
**Pharmacy:**

SSN (Patient): \_\_\_\_\_ Home Phone Number: ( ) \_\_\_\_\_

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

Last name First Name Middle Initial  
Work phone number: ( ) \_\_\_\_\_ Email address: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender:  Male  Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Single  Married  Separated  Divorced

Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_  Self  Insurance  WCI  Other

Insurance Company Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_ Group: \_\_\_\_\_ ID#: \_\_\_\_\_

Are you covered under any of these programs?  Medicare  Medicaid  Worker's Compensation

In case of emergency, who should be notified? \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**Consent for Medical Treatment:** I consent to treatment-as deemed necessary and appropriate by the physician or nurse practitioner.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Insurance Coverage/Payments:** I hereby agree to pay the University of Texas Health Services (UTHS) for all charges incurred by me while being treated as a patient at UTHS. I hereby authorize my insurance company to pay directly to UTHS, and/or the designated physician any benefits due me by reason of services described in statement rendered, and I further hereby assign any and all claims for benefits arising under the terms of such policy of insurance named above to UTHS and its treating physicians and nurse practitioners. I further authorize UTHS to give the named insurance company all information necessary for the determination of the benefits due under such policy of insurance. I also authorize the use of photographic reproduction of this authorization in place of original.

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Record usage:** By signing below I give my consent for UTHS to use my medical record for data gathering and research purposes. I understand that ALL identifying information in my record will be coded for confidentiality. I understand that all patient/medical provider communication will be held in the strictest confidence.

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_