BAYLOR Medical Center at Uptown

Now part of Baylor Scott & White Health

PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

LAST NAME: _____ FIRST NAME: _____ MI: _____

SSN#: _____ DOB: _____ GENDER: M ☐ F ☐

ADDRESS: _____

CITY: _____ STATE: _____ZIP: _____

HOME #: _____MOBILE #: _____

MARITAL STATUS: _____MARRIED _____SINGLE _____DIVORCED _____OTHER

RELIGIOUS PREFERENCE: _____ PREFERRED LANGUAGE: _____

EMPLOYER: _____ EMPLOYMENT STATUS: _____

EMERGENCY CONTACT: _____ PHONE #: _____

EMAIL ADDRESS: (E-Survey purpose only) _____

INSURANCE INFORMATION

PRIMARY: _____ POLICY #: _____ GRP #: _____

POLICY HOLDER: _____ DOB: _____ SSN #: _____

REL TO PATIENT: _____ EMPLOYER: _____

SECONDARY: _____ POLICY: _____ GRP #: _____

POLICY HOLDER: _____ DOB: _____ SSN #: _____

REL TO PATIENT: _____ EMPLOYER: _____

WORKERS COMP CARRIER: _____CLAIM #: _____

ADJUSTER: _____ PHONE #: _____

PLEASE BRING YOUR DRIVERS LICENSE AND ALL INSURANCE CARDS ON YOUR DATE OF SERVICE
THANK YOU