

**Texoma Medical Center – TexomaCare: Patient Registration / Informacion Sobre El/La Paciente**

**GUARANTOR INFORMATION / INFORMACION DEL GARANTIZADOR**

*Head of Household's Last, first name and middle initial / Garantizador: Apellido, Nombre <small>*this person would be responsible and receive the bills after insurance responded</small>			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono
Physical Address / Direccion: Numero Calle Ciudad Estado Zono Postal			
Mailing Address, if different from Physical Address / Otro Direccion			
Head of Household's Employer / Patron De Garantizador		Employer's Telephone # Numero de Telefono del Patron de Garantizador	

**PATIENT INFORMATION, Part I / INFORMACION DEL PACIENTE I**

Patient Last, first name and middle initial / Paciente: Apellido, Nombre			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono
Mailing Address, if different from Guarantor's / Direccion: si es Diferente de el Garantizador			Relationship to Guarantor Relacion at Garantizador

**ADDITIONAL FAMILY MEMBERS / MEMBROS ADICIONAL A LA FAMILIA**

Last, first name and middle initial / Apellido, Nombre			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono
Mailing Address, if different from Guarantor's / Direccion: si es Diferente de el Garantizador			Relationship to Guarantor Relacion at Garantizador

**ADDITIONAL FAMILY MEMBERS / MEMBROS ADICIONAL A LA FAMILIA**

Last, first name and middle initial / Apellido, Nombre			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono
Mailing Address, if different from Guarantor's / Direccion: si es Diferente de el Garantizador			Relationship to Guarantor Relacion at Garantizador

**ADDITIONAL FAMILY MEMBERS / MEMBROS ADICIONAL A LA FAMILIA**

Last, first name and middle initial / Apellido, Nombre, Segundo Nombre			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono
Mailing Address, if different from Guarantor's / Direccion: si es Diferente de el Garantizador			Relationship to Guarantor Relacion at Garantizador



**GUARANTOR INFORMATION**

**PATIENT INFORMATION, Part II (if applicable)/ INFORMACION SOBRE EL PACIENTE (si es aplicable)**

Patient's Employer / Patron de Paciente	Patient Employer's Telephone# / numero de Telefono de Patron de Paciente
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**EMERGENCY CONTACT / EN CASO DE EMERGENCIA**

Emergency Contact / En caso de Emergencia Llama	Emergency Contact's Telephone # / Numero de Telefono
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**INSURANCE INFORMATION / INFORMACION SOBRE ASEGURANCIA**

<b>Primary Insurance</b>	ID or Policy # / Numero de Poliza	Phone # / El teléfono #	Group # / Numero de Grupo
<b>Nombre de la Compania de Asegurancia Primario</b>			
Subscriber's Name (who owns the policy)	Date of Birth	Employer / Patron de Suscriptor	Effective Date
Nombre de Suscriptor	Fecha de Nacimiento		Fecha de Valido
<b>Secondary Insurance</b>	ID or Policy # / Numero de Poliza	Phone # / El teléfono #	Group # / Numero de Grupo
<b>Nombre de la Compania de Asegurancia Secundario</b>			
Subscriber's Name (who owns the policy)	Date of Birth	Employer / Patron de Suscriptor	Effective Date
Nombre de Suscriptor	Fecha de Nacimiento		Fecha de Valido
<b>Tertiary Insurance</b>	ID or Policy # / Numero de Poliza	Phone # / El teléfono #	Group # / Numero de Grupo
<b>Nombre de la Compania de Asegurancia Tercario</b>			
Subscriber's Name (who owns the policy)	Date of Birth	Employer / Patron de Suscriptor	Effective Date
Nombre de Suscriptor	Fecha de Nacimiento		Fecha de Valido

**CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY  
MEDICAL PERMISO para TRATAMIENTO y RESPONSIBLE de PAGOS**

The patient agrees to general medical treatment by TexomaCare physicians and understands and consents to the review and use of his/her medical records by any TexomaCare physician. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to that the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

Deside usted que le van a dar tratamiento medico general, por los doctores de TexomaCare y consultar con ostros doctores de TexomaCare. Todos los servicios son la responsabilidad de usted. Lienamos las formas para cobrar a su asegurancia, pero usted es responsable por los cobros. Es costumbre pagar por servicios el mismo dia o tal vez si a hecho otros arreglamentos antes de la cita.

**INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS  
PERMISO para ASEGURANCIA y BENIFICCIOS**

I hereby authorize TexomaCare to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any TexomaCare physician. I further agree that this authorization to release information and assignment of benefits shall remain in effect for one calendar year unless and until it is revoked in writing by me.

**HIPAA – NOTICE OF PRIVACY PRACTICES**

This notice describes how medical information about you and/or spouse/children may be used and disclosed and how you can get access to this information. I acknowledge that the TexomaCare Notice of Privacy Practices has been provided.  
Signature of patient / legal representative:

**PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR**

The authorization form is to give consent to someone(s) other than a parent/legal guardian for the medica treatment of the patient for any unhealthy condition or well visits.

Signature of Head of Household, Parent or Patient / Garantizador: Apellido, Nombre	Date / Fecha de Firma
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**OFFICE USE**

Data Collected by Whom:	Date of Data Collection:	Data Entered by Whom (PLUS):	Date of Data Entered:
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**PATIENT INFORMATION**

Form#7180-206b(Rev.02/20/2007-gw)