HOUSTON Methodist LEADING MEDICINE

PRE-OP REGISTRATION REQUEST

Patient Registration (713) 394-6805 Fax (713) 790-3700

Section				
PATIENT DATA	PATIENT'S LAST NAME FIRST NAME MI	DOB	SSN	
	PATIENT ADDRESS	CITY, STATE ZIP		
	SEX (CIRCLE ONE) MALE FEMALE	MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED SEPARATED WIDOWED	RACE (CIRCLE ONE) CAUCASIAN AFRICAN AMERICAN AMERICAN INDIAN ASIAN PACIFIC ISLANDER HISPANIC OTHER	
	E-MAIL ADDRESS	HOME PHONE	WORK PHONE	CELL PHONE
	HOW DO YOU PREFER THAT WE CONTACT YOU? (CIRCLE ONE) EMAIL HOME PHONE # WORK PHONE # CELL PHONE # MAIL	WHEN IS THE BEST TIME TO CONTACT YOU? ______AM ______PM		
	NEAREST RELATIVE	RELATIONSHIP TO PATIENT	BEST CONTACT PHONE NUMBER	
	EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	BEST CONTACT PHONE NUMBER	
BILLING DATA	GUARANTOR NAME (IF NOT THE PATIENT)	GUARANTOR DOB	GUARANTOR SSN	
	ADDRESS	CITY, STATE ZIP	GUARANTOR PHONE #	
WORKER'S COMP	**IS THIS VISIT DUE TO AN ON THE JOB INJURY? (CIRCLE ONE) YES NO IF YES, COMPLETE THIS SECTION**	CHIEF COMPLAINT/TYPE OF INJURY	DATE OF INJURY /ACCIDENT	
	ADJUSTER'S NAME	PHONE	CLAIM NUMBER	
	NAME OF INSURANCE CO			
	INSURED'S NAME			
	EMPLOYER NAME AND ADDRESS	EMPLOYER PHONE #		
INSURANCE DATA	**NAME OF PRIMARY INSURANCE CO AND ADDRESS**	PRECERT PHONE # VERIFICATION PHONE #		
	INSURED'S NAME	POLICY/CLAIM NUMBER		
	EMPLOYER/GROUP NAME	GROUP NUMBER		
	NAME OF SECONDARY INSURANCE CO AND ADDRESS	PRECERT PHONE # VERIFICATION PHONE #		
	INSURED'S NAME	POLICY/CLAIM NUMBER		
	EMPLOYER/GROUP NAME	GROUP NUMBER		
	MEDICARE PART A EFFECTIVE DATE PART B EFFECTIVE DATE	MEDICARE NUMBER		

COMMENTS: