Today's Date:_____

Patient Information

Full Name: Last	First	Middle	(Maiden)	
Address: (Street or Box)	City	State	Zip	
Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )	Email Address	
Date of Birth	Age	Sex (circle one) Male Female	Social Security #	
Occupation	Employer	Employer Address		
Marital Status (circle one) Single Married Widowed Divorced Separated		Spouse's Name		
If Student, Indicate School	If Patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation required):			
Emergency Contact (not living at same address)		Emergency Contact Phone # ( )		

Your Physicians

Referring Physician:		Phone # ( )	
Address: (Street or Box)	City	State	Zip
Primary Care Physician:	Phone # ( )	Address:	
Other Physicians:	Address and Phone:		

Insurance Information

Name of **Primary** Insurance Company **1.** Phone # ( )	Name of **Secondary** Insurance Company **2.** Phone # ( )
Mailing Address	Mailing Address
City State Zip	City State Zip
Policy Number Group Number Effective Dates of Policy From: To:	Policy Number Group Number Effective Dates of Policy From: To:
Policy Holder (if other than patient) Date of Birth	Policy Holder (if other than patient) Date of Birth
Social Security # Relationship to Patient	Social Security # Relationship to Patient
Policy Holder's Employer Work Phone # ( )	Policy Holder's Employer Work Phone # ( )
Employer Address	Employer Address
City State Zip	City State Zip

PATIENT REGISTRATION FORM

Baylor Liver and Pancreas Disease Center

Patient Name: _____

Consent to Treat

By signing this form, I authorize employees and agents; including physicians, physician assistants and nurse practitioners of HTPN-Transplant Services, LLP to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

If patient is a minor:
I consent for _____to authorize evaluation and treatment for my child named
(Name(s): First & Last)
herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____

Signature of Patient, Parent, or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas Provider Network (hereinafter "HTPN") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to HTPN. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HTPN, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____

Signature of Patient, Parent, or Legal Guardian **Date**