HOUSTON Methodist℠
LEADING MEDICINE

PRE-OP REGISTRATION REQUEST

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

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: