TCA | HEALTH

REGISTRATION FORM

PATIENT

Last Name	First Name	MI	Sex: M or F	Date of Birth / /
Address	City		State	Zip Code
Phone # ( )	Marital Status	Student Status	Are you an Altgeld Murray (Garden) Resident?	Yes or No
	S M W D SEP	F/P	Do you live in Public Housing?	Yes or No
Cell Ph # ( )	E-Mail Address:		Consent to call YES or NO	Consent to Text Yes or No

Race: Asian____ Native Hawaiian____ Pacific Islander___ Black/African___ American Indian/Alaska Native___ White___ Other_____

Ethnicity: Hispanic or Non Hispanic Are you a Veteran? ___Yes ___No Household Size_____ Monthly Income

Emergency Contact:	Relationship to Patient:	Phone #	Allergies:
Employment Status	Employer Name	Work Phone # ( )	Social Security Number
Employer Address	City	State	Zip Code
Referred by		Ph # of Referral ( )	

Responsible Party (Complete this section if the person responsible for the bill is not the patient)

Last Name	First Name	MI	Sex F M	Date of Birth
Address	City	State	Zip	Social Security Number
Relation to Patient ____Spouse ___Parent _____Other	Employer Name		Work Phone # ( )	
Spouse or Parent (if minor):		Home Phone # ( )		

Insurance (If you have multiple coverage, supply information from both carriers)

Primary Carrier Name	Date of Birth	Secondary Carrier Name	Date of Birth
Name of the Insured (Name on ID Card)		Name of the Insured (Name on ID Card)	
Patient's relationship to the insured ____Self ____Spouse ____Child		Patient's relationship to the insured __Self ___Spouse __ Child	
Insured ID#		Insured ID#	
Group # or Company Name		Group # or Company Name	
Insurance Address		Insurance Address	
Phone # ( )	Copay $	Phone # ( )	Copay $

Other Information

Is patient's condition related to: Reason for visit:

_____Employment ____ ___Auto Accident (if yes, state in which accident occurred: _____) _____Other Accident

Date of Accident: / / Date of First Symptom of Illness: / /

Financial Agreement and Authorization for Treatment

I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements, promptly upon their presentation, unless credit arrangements are agreed upon in writing.

I hereby authorize direct payment of surgical/medical benefits to TCA Health, Inc. for services rendered by the clinician/ provider in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize the release of any medical information necessary in order to process a claim for payment on my behalf.

Signature Date: