# Welcome *Patient Registration*

Texas Injury Clinic

| PATIENT INFORMATION | | | |
|---|---|---|---|
| **Patient Name** | | **DOB** | ☐ M ☐ F |
| **Address** | | **SSN** | |
| **City** | | **State** | **Zip** |
| **Driver's License No.** | **State** | **Home Phone** | |
| **Email Address** | | **Cell Phone** | |
| **Primary Care Physician** | | **Phone** | |
| **Emergency Contact** | | **Phone** | |
| **How did you hear about Texas Injury Clinic?** | | | |

| EMPLOYER INFORMATION | | | |
|---|---|---|---|
| **Company** | | **Phone** | |
| **Address** | | **Fax** | |
| **City** | | **State** | **Zip** |
| **Supervisor's Name** | | **Reported to Supervisor?** ☐ Yes ☐ No | |
| **Medical Rep** | | **Phone** | |
| **Job Description** | | | |

| GUARANTOR - RESPONSIBLE PARTY | | | |
|---|---|---|---|
| **Insured** | | **DOB** | ☐ M ☐ F |
| **Home Phone** | | **SSN** | |

| INJURY INFORMATION | |
|---|---|
| **Date of Injury** | **Type of Injury:** ☐ Motor Vehicle ☐ Work ☐ Sports ☐ Other |
| **Would you like help finding an attorney?** ❑ Yes ❑ No | |

| INSURANCE INFORMATION | | | |
|---|---|---|---|
| **Company** | | **Claim #** | |
| **Address** | | **Group #** | |
| **City** | | **State** | **Zip** |
| **Adjuster** | | **Phone** | |
| | | **Fax** | |

| ATTORNEY INFORMATION | | | |
|---|---|---|---|
| **Name** | | **Phone** | |
| **Address** | | **Fax** | |
| **City** | | **State** | **Zip** |
| **Do you have an accident report?** ❑ Yes ❑ No | | | |

I AUTHORIZE MY INSURANCE BENFITS TO BE PAID DIRECTLY TO TEXAS INJURY CLINIC. I UNDERSTAND THAT I AM FINANCIALLY RSPONSIBLE FOR ANY BALANCE. I AUTHORIZE TEXAS INJURY CLINIC OR MY INSUANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIM.

**Signature of Patient / Legal Guardian and Relationship to Patient** **Date**

**Printed Name of Patient / Legal Guardian**