

Fax to: 214 818-5223

OUTPATIENT REGISTRATION DATA

Please Print

Medical Service Code _____ Ext. _____ Location: _____ Date of Service _____

MD's Full Name _____ CHECK ONE: _____ One-Time OP _____ Series OP _____

Symptoms _____ Procedure _____

PATIENT INFORMATION

ICD 9 Codes required for Medicare

Last Name _____ First Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

Phone# (____) _____ D.O.B _____ Spouse's Name _____

Soc. Sec. # _____ Gender: M ___ F ___ Ethnicity: Hispanic _____ Non-Hispanic _____

Race: White ___ Black ___ Asian/Pacific Isl ___ Native Amer/Aleut ___ Other ___ Marital Status: M ___ D ___ W ___ S ___

PATIENT EMPLOYER INFORMATION

Company Name: _____ Occupation _____ Phone# (____) _____

Address _____ City _____ State _____ Zip _____

GUARANTOR OR FINANCIALLY RESPONSIBLE PARTY

Name _____ Soc. Sec # _____ Relationship _____

Date of Birth _____ Phone No. _____

Address _____ City _____ State _____ Zip _____

INJURY INFORMATION

Was your injury the result of an ACCIDENT? Date _____ Time _____ Place _____

Description _____ Work related accident? Adjuster's Name _____ Phone# _____

PRIMARY INSURANCE

Name _____ Address _____

I.D.# _____ Group#or Insured's Employer _____

Member Service Phone#(____) _____ Pre-certification Phone# (____) _____

Insured's Name _____ Relationship _____ DOB _____

SECONDARY INSURANCE

Name _____ Address _____

I.D.# _____ Group#or Insured's Employer _____

Member Service Phone#(____) _____ Pre-certification Phone# (____) _____

Insured's Name _____ Relationship _____ DOB _____

Legend:

BAYLOR UNIVERSITY MEDICAL CENTER

DALLAS, TEXAS



50863 (Rev. 06/08)

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