Diabetes and Thyroid Center of Fort Worth, PLLC
Darren Lackan, MD, PA ● Chris Bajaj, DO, PA
Anjanette Tan, MD, PA ● Christopher Hudak, MD

REGISTRATION FORM

(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Nickname:	Former Name:	Birth Date: / /	Age:	Sex: ☐ M ☐ F

Street Address:	City:	State:	ZIP Code:

Social Security #:	Home Phone #: ( )	Cell Phone #: ( )

Occupation:	Employer:	Employer Phone #: ( )

Referred to clinic by:	☐ Dr.

GUARANTOR INFORMATION

☐ Check if same as patient information

Person responsible for bill:	Birth Date: / /	Address (if different):	Home Phone #: ( )

Is this person a patient here? ☐ Yes ☐ No

Social Security #:	Employer:	Employer address:	Employer #: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance:	Subscriber's Name:

Subs. Social Security #:	Birth Date: / /	Group #:	Policy #:	Co-payment:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of secondary insurance (if applicable):	Subscriber's Name:

Subs. Social Security #:	Birth Date: / /	Group #:	Policy #:	Co-payment:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone #: ( )	Work Phone #: ( )