Baylor Scott & White MEDICAL CENTER LAKEWAY

Part of Baylor Scott & White Medical Center – Round Rock

Patient Label

Registration Form

PLEASE FILL OUT COMPLETELY

Patient Demographics

Full Legal Name - DO NOT use nicknames

Last Name:

First: Middle:

Mailing Address:

Apt./Unit No.: City:

State: Zip:

Primary Contact No.: ( )

DOB: Gender: ☐ F ☐ M

Social Security No.:

Race: ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Marital Status:

E-Mail:

Religion Preference:

Place of Worship:

Veteran Status: ☐ Veteran ☐ Not a Veteran ☐ Spouse of Vet

Reason for ER Visit

Symptoms/Complaint:

Onset Date and Time:

Accident Type (only to be used for auto accidents):
☐ Employment Related ☐ Medical Coverage ☐ Tort ☐ No-Fault
☐ No Med/Liab ☐ Crime Victim ☐ Home Accident ☐ Other

FOR OFFICE USE ONLY

Date: Mode of Arrival:

Room No.: Source of ID:

Attending Physician:

Insurance (if applicable): ☐ Self-Pay

Total Due: $ ☐ Co-Pay ☐ Co-Ins (%) ☐ Dep

Emergency Contact Information

Name:

Relationship to Patient:

Home/Cell Phone No.: ( )

Mailing Address:

Apt./Unit No.: City:

State: Zip:

Patient's Employment Information

☐ Full Time ☐ Part Time ☐ Retired (retirement date: ____/____/____)

☐ Self Employed ☐ Unemployed ☐ Student (adult) ☐ Minor (N/A)

Patient's Employer:

Occupation:

Work Phone No.: ( )

Mailing Address:

Suite No.: City:

State: Zip:

Patient's Primary Care Physician (PCP) Information

Doctor/Clinic Name:

Office Phone No.: ( )

Mailing Address:

Suite No.: City:

State: Zip:

Insurance Holder's Information

Relationship to Patient: ☐ Self

Insured's Name:

Insured's Date of Birth:

Insured's Social Security No.:

Insured's Contact No.: ( )

Insured's Employer:

If applicable, please provide insurance card