QUOC-HUNG TRAN, MD, PA
Psychiatry and Behavioral Sciences
17736 Preston, Suite 101 • Dallas, TX 75252 • 972.248.2299

PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last*)____

Date of Birth ________________ Age _______________ Male / Female Marital Status: S M W D

Address ____

Phone Number ______________ Social Security # ____________________ Driver's License #____________

Employer ____ Phone __________________

Employer Address ____

Referring Physician ____

If Student, School Name ____ Full-Time / Part-Time

Responsible Party

Name ____________________________________ Relationship to Patient ________________

Address____

Phone Number _________________ Social Security # ____________________

Employer ____ Phone Number __________________

Employer Address____

Emergency Contact ________________________________ Phone Number __________________

Insurance Information

Insurance Company ________________________________ Phone Number __________________

Address ____

Group # ____________________________ Certificate or ID # ____________________________

Insured's Name ____________________________ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer ________________________________ Phone Number ___________________

Employer Address____

Insured's Social Security # ___________________ Date of Birth ____________________ Male / Female

I hereby assign, transfer, and set over to QUOC-HUNG TRAN, MD, PA all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature ____________________________________ Date _______________________