

**Diabetes and Thyroid Center of Fort Worth, PLLC**  
**Darren Lackan, MD, PA    Chris Bajaj, DO, PA**

**REGISTRATION FORM**

(Please Print)

Today's Date:					
<b>PATIENT INFORMATION</b>					
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital Status (circle one)
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid
Nickname:	Former Name:		Birth Date:	Age:	Sex:
			/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Street Address:			City:	State:	ZIP Code:
Social Security #:		Home Phone #:		Cell Phone #:	
		( )		( )	
Occupation:	Employer:			Employer Phone #:	
				( )	
Referred to clinic by:			Email address:		
<b>GUARANTOR INFORMATION</b>					
<input type="checkbox"/> Check if same as patient information					
Person responsible for bill:		Birth Date:	Address (if different):	Home Phone #:	
		/ /		( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Social Security #:	Employer:		Employer address:	Employer #:	
				( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>INSURANCE INFORMATION</b>					
Primary Insurance:			Subscriber's Name:		
Subs. Social Security #:		Birth Date:			Co-payment:
		/ /			
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of secondary insurance (if applicable):			Subscriber's Name:		
Subs. Social Security #:		Birth Date:			Co-payment:
		/ /			
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
<b>IN CASE OF EMERGENCY</b>					
Name of local friend or relative (not living at same address):		Relationship to Patient:	Home Phone #:	Work Phone #:	
			( )	( )	

