



Women's Center  
*for* Comprehensive Care  
at Baylor College of Medicine

www.bcm.edu/womenscenter  
713.798.2545

*Patient Registration*

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Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact By: Home Phone \_\_\_\_ Work Phone \_\_\_\_ Fax \_\_\_\_ Cell Phone \_\_\_\_ Cell#: \_\_\_\_\_

Sex: M \_\_\_\_ F \_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Language: \_\_\_\_\_

Marital Status: Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Separated \_\_\_\_ Other \_\_\_\_\_

Race: Black \_\_\_\_ Chinese \_\_\_\_ Filipino \_\_\_\_ Hispanic \_\_\_\_ Japanese \_\_\_\_ Multiracial \_\_\_\_ Native American \_\_\_\_

Native Hawaiian \_\_\_\_ Oriental/Asian \_\_\_\_ Pacific Islander \_\_\_\_ White \_\_\_\_ Other \_\_\_\_\_

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Responsible Party (Party responsible for payment): Self \_\_\_\_ Spouse \_\_\_\_ Parent \_\_\_\_ Other \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Primary Insurance: \_\_\_\_\_

HMO or PPO?

Claim Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Insured Party: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Employer: \_\_\_\_\_

Guarantor: \_\_\_\_\_ Guarantor Date of Birth: \_\_\_\_\_

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Secondary Insurance: \_\_\_\_\_

HMO or PPO?

Claim Mailing Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Insured Party: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Employer: \_\_\_\_\_

Guarantor: \_\_\_\_\_ Guarantor Date of Birth: \_\_\_\_\_

Women's Center for Comprehensive Care  
Baylor Clinic  
6620 Main Street  
12th Floor, Suite 1225  
Houston, TX 77030  
713.798.2545

