

**HARRIS COUNTY HOSPITAL DISTRICT
PATIENT REGISTRATION FORM**

To Be Completed by Research Personnel and faxed to Bettye Crayton, Admitting, @ 713.873.2278

- **HOSPITAL/HEALTH CENTER** (check specific box)

BTGH LBJ QM TSC CHP: _____
Specify

- **SCHOOL AFFILIATION** (check specific box)

UTHSC-Houston BCM MDACC Other: _____
Specify

- **RESEARCH STUDY ACCOUNT** (This information is needed at the initial set-up)

Research Study Protocol Number _____

Principal Investigator _____

Administrative Contact _____

Investigator's Billing Address _____

Investigator's Phone #: _____ Fax #: _____

E-mail: _____

Insurance Plan Assigned: _____
(to be assigned by Patient Registration)

- **PATIENT REGISTRATION for RESEARCH ACCOUNT** (This information is needed for each patient enrolled in the study)

Patient Name: _____

Medical Record #: _____

SSN #: _____ DOB: _____

Sex: _____ M _____ F RACE: _____

Address: _____

Mother's Name: _____

Date submitted: _____ Date needed: _____

Requested by: _____

Phone #: _____ Fax #: _____

For Patient Registration Use Only:

Date received: ____/____/____ Received by: _____

Date entered: ____/____/____ Entered by: _____