

PATIENT INFORMATION

ACCOUNT NUMBER (office use only)

- Austin Surgical Plaza
 Marble Falls
 Round Rock
 Dr. Blauzvern
 Dr. Dryer
 Dr. Onan
 Dr. Smith
 Dr. Wupperman

Thank you for selecting us to be a part of your healthcare team. We know that this is an important decision and we will work hard to justify your confidence in us.

PLEASE PRINT

NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER
HOME ADDRESS					CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE / PAGER	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> OTHER	DRIVER'S LICENSE NO.	OCCUPATION		STUDENT <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	
EMPLOYER/SCHOOL NAME			EMPLOYER/SCHOOL ADDRESS				
CITY			STATE	ZIP CODE	BUSINESS PHONE	EMAIL ADDRESS	
IN CASE OF EMERGENCY, NOTIFY				PHONE NO.		DRUG ALLERGIES	
HOW DID YOU LEARN ABOUT US: <input type="checkbox"/> DOCTOR REFERRAL <input type="checkbox"/> FRIEND REFERRAL <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> WEBSITE <input type="checkbox"/> INSURANCE BOOKLET				REFERRING DOCTOR		PRIMARY CARE PHYSICIAN	

POLICY HOLDER INFORMATION

RESPONSIBLE PARTY		DATE OF BIRTH	SEX	DRIVER'S LICENSE NUMBER	SOCIAL SECURITY NUMBER
HOME ADDRESS				CITY	STATE ZIP CODE
HOME PHONE	BUSINESS PHONE	EMPLOYER/SCHOOL NAME			
EMPLOYER/SCHOOL ADDRESS				CITY	STATE ZIP CODE

INSURANCE INFORMATION

PRIMARY INSURANCE TYPE <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> INDEMNITY			SECONDARY INSURANCE TYPE <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> INDEMNITY		
PRIMARY INSURANCE COMPANY NAME			SECONDARY INSURANCE COMPANY NAME		
INSURANCE COMPANY ADDRESS			INSURANCE COMPANY ADDRESS		
GROUP NUMBER	POLICY NUMBER		GROUP NUMBER	POLICY NUMBER	
SUBSCRIBER'S NAME	SUBSCRIBER'S SSN NO.	SUBSCRIBER'S DOB	SUBSCRIBER'S NAME	SUBSCRIBER'S SSN NO.	SUBSCRIBER'S DOB
PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		

INJURY / ACCIDENT INFORMATION

IF INJURY/ACCIDENT <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> MOTOR VEHICLE/STATE _____ <input type="checkbox"/> OTHER		DATE OF ONSET	DATE LAST WORKED
IF REPRESENTED BY ATTORNEY-NAME OF ATTORNEY		ADDRESS	PHONE NO.

PAYMENT IS EXPECTED AT TIME OF SERVICE. PLEASE BE PREPARED TO PAY ALL COPAYMENT AND DEDUCTIBLE AMOUNTS METHOD OF PAYMENT CASH CHECK BANK CARD

RELEASE OF MEDICAL RECORDS AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize the release of requested medical information and / or records to my primary care physician, insurance company, third party review organization, peer review physician, employer or their representatives.
 I understand that I am responsible for all charges not paid by my insurance company, subject to any contractual limitations between my physician and insurance company or managed care network.
 I understand that I am responsible for promptly responding to my insurance company to provide any additional information they may request regarding my treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in my account becoming due and payable, in full, immediately.
 I will be prepared to present my insurance card and proof of identity (e.g. driver's license) at each visit. I will provide a change of address, telephone number and / or insurance information any time a change occurs.

SIGNATURE OF RESPONSIBLE PARTY	DATE
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