

PATIENT INFORMATION

ACCOUNT NUMBER (office use only)

Austin Surgical Plaza

Marble Falls

Dr. Blauzvern

Dr. Dwyer

Dr. Onan

Dr. Smith

Dr. Wupperman

Thank you for selecting us to be a part of your healthcare team. We know 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 #
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 #	OCCUPATION		STUDENT <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
EMPLOYER / SCHOOL NAME			EMPLOYER / SCHOOL ADDRESS			
CITY	STATE	ZIP CODE	BUSINESS PHONE ()	DRUG ALLERGIES		
IN CASE OF EMERGENCY, NOTIFY			PHONE NUMBER ()			
HOW DID YOU LEARN ABOUT US? <input type="checkbox"/> DOCTOR <input type="checkbox"/> FRIEND <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> WEBSITE <input type="checkbox"/> INSURANCE BOOKLET				REFERRING DOCTOR	PRIMARY CARE PHYSICIAN	

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY		DATE OF BIRTH	SEX	DRIVER'S LICENSE #	SOCIAL SECURITY #
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 SSN #	SUBSCRIBER DOB	SUBSCRIBER'S NAME	SUBSCRIBER SSN #	SUBSCRIBER 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 OR ACCIDENT <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> MOTOR VEHICLE / STATE _____ <input type="checkbox"/> OTHER		DATE OF INJURY	DATE LAST WORKED
IF REPRESENTED BY ATTORNEY - NAME OF ATTORNEY	ADDRESS	PHONE NUMBER ()	

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 _____

Please answer all questions completely, sign and date this form, and bring it with you to your first appointment with the doctor. You will also need to bring any x-rays, MRI or CT scans, your insurance card and proof of identity with you to your appointment. If you have questions, please call our office at 512 795-2225.