

PATIENT INFORMATION

Please fill out all of the following Information

PATIENT INFORMATION

Name of Patient: _____ Gender: Male Female

Address: _____

City: _____ State & Zip: _____

Date of Birth: ____ / ____ / ____ Social Security Number: _____

Phone #: (____) _____ Alternate Phone #: (____) _____

Employer: _____ Work #: _____

PATIENT/GUARDIAN INFORMATION

If patient is a Minor, Name of Parent/Guardian: _____

Relationship to Patient: _____

Phone #: (____) _____ Alternate Phone #: (____) _____

Employer: _____

INSURANCE INFORMATION

Insurance Company: _____ PCP Name: _____

Policy/ID Number: _____ Group Number: _____

Insurance Address: _____

Insurance Phone #: (____) _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Social Security #: _____

Policy Holder's Employer: _____

Employer's Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ PCP Name: _____

Policy/ID Number: _____ Group Number: _____

Insurance Address: _____

Insurance Phone #: (____) _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Employer: _____

Employer's Address: _____

EMERGENCY INFORMATION

Name of person to contact in case of emergency: _____

Relationship to Patient: _____ Phone #: (____) _____

MEDICAL CARE: I authorize the physicians of Austin Medical Education Program to provide myself or my child with reasonable and proper medical care according to today's standard.

MEDICAL INFORMATION: I authorize the Physician's staff of this office to release any and all information in their possession they have acquired in the course of my or my child's treatment to my insurance company or companies, my employer or any third party payer so that they may obtain payment for medical services rendered.

INSURANCE AUTHORIZATION: I hereby authorize the Physicians of this office to furnish information to my insurance carriers concerning myself or my child's illness and treatments.

ASSIGNMENT OF BENEFITS: I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim.

I ALSO AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ALL OR A PORTION OF THE CHARGES.

SIGNATURE (Patient, Parent or Guardian): _____ **Date:** _____