PATIENT INFORMATION

ACCOUNT NUMBER (office use only)

☐ Austin Surgical Plaza

☐ Dr. Blauzvern ☐ Dr. Dryer

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	DRIVER'S LICENSE NO.	OCCUPATION	STUDENT
( )	( )	☐ S ☐ M ☐ OTHER			☐ FULL TIME ☐ 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:	REFERRING DOCTOR	PRIMARY CARE PHYSICIAN
☐ DOCTOR REFERRAL ☐ FRIEND REFERRAL ☐ YELLOW PAGES ☐ WEBSITE ☐ INSURANCE BOOKLET		

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	SECONDARY INSURANCE TYPE
☐ PPO ☐ HMO ☐ MEDICARE ☐ MEDICAID ☐ INDEMNITY	☐ PPO ☐ HMO ☐ MEDICARE ☐ MEDICAID ☐ 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	PATIENT'S RELATIONSHIP TO SUBSCRIBER
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INJURY / ACCIDENT INFORMATION

IF INJURY/ACCIDENT	DATE OF ONSET	DATE LAST WORKED
☐ HOME ☐ WORK ☐ MOTOR VEHICLE/STATE _____ ☐ OTHER		

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

Print