PATIENT INFORMATION

PATIENT NAME____ MALE _______ FEMALE _________

MAILING ADDRESS:____________________________ DATE OF BIRTH ________/_______/_________

____ SSN ____________________________________

CITY ________________________ ST______ ZIP___ MARITAL STATUS _______________________

HOME PHONE _______________________________ PATIENT EMPLOYMENT FT__PT__SELF__RET__

CELL PHONE_________________________________ EMAIL ____

HOW WERE YOU REFERRED TO OUR OFFICE? PHYSICIAN___ FAMILY/FRIEND___ NEWSPAPER___

YELLOW PAGES___ INSURANCE COMPANY___ DR. AUSTIN'S WEBSITE___ OTHER__________________

ONLY IF PHYSICIAN REFERRED YOU: NAME, ADDRESS, AND PHONE # ____________________________

____

NAME, ADDRESS, AND PHONE NUMBER OF PERSON FINANCIALLY RESPONSIBLE, IF DIFFERENT FROM PATIENT ____

____

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN NAME____ __________________

SUBSCRIBER POLICY # ______________________________ GROUP/PLAN#________ __________________

SUBSCRIBER/POLICY SUBSCRIBERS

HOLDER NAME_______________________________________ EMPLOYER _________ __________________

ADDRESS____ ADDRESS _________ __________________

PHONE NUMBER____________________________________ _ ____

SSN_________________________ SEX MALE____ FEMALE____ OCCUPATION___ __________________

EXACT RELATIONSHIP_________________________ SUBSCRIBERS DOB ______/__ ______/___________

SECONDARY INSURANCE

SECONDARY INSURANCE PLAN NAME_____________________________________ __________________

SUBSCRIBER POLICY # ______________________________ GROUP/PLAN#________ __________________

SUBSCRIBER/POLICY SUBSCRIBERS

HOLDER NAME_______________________________________ EMPLOYER_________ __________________

ADDRESS____ ADDRESS ____________________________

PHONE NUMBER____________________________________ __________ ____________________________

SSN_________________________ SEX MALE____ FEMALE____ OCCUPATION___ __________________

EXACT RELATIONSHIP_________________________ SUBSCRIBERS DOB ____/____ __/______________

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO CRAIG AUSTIN, M.D. FOR SERVICES FURNISHED TO ME BY THE PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENT'S SIGNATURE____ DATE_____ __________________