

## Austin Medical Associates

### **PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_  
Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
SS# \_\_\_\_\_ Marital Status: Single  Married  Divorced  Widowed   
Employer Name \_\_\_\_\_ Address \_\_\_\_\_ Phone# \_\_\_\_\_  
Full time  Part Time  Student  Retired  (If retired, retirement date) \_\_\_\_\_  
Who may we thank for your referral? \_\_\_\_\_ Pharmacy \_\_\_\_\_

### **INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Secondary/Supplemental Insurance \_\_\_\_\_ Policy# \_\_\_\_\_  
Group# \_\_\_\_\_  
If the primary carrier of one of your insurance policies is NOT yourself, please supply us with the following information for that person, so we may properly file your insurance claim.  
Does the primary insured carry your primary insurance  secondary insurance  or both insurance policies ?  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_ Country \_\_\_\_\_ Phone #1 \_\_\_\_\_  
Phone #2 \_\_\_\_\_ - Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Your relationship to the insured? Self  Spouse  Other \_\_\_\_\_

### **EMERGENCY CONTACT**

Name \_\_\_\_\_ Phone # \_\_\_\_\_

AUTHORIZATION: I hereby authorize Assignment of Benefits to Jerry Vandel, M.D., Steven Booton, M.D. and/or Mousumi Chanda-Kim, M.D. I also certify that I will be responsible for the payment of services provided but not covered. I also authorize the Clinic and Doctors to release Medical Records and other information to Insurance Companies.

I acknowledge that physicians do not accept assignment of benefits on all insurance companies including Medicare. (Please check with the receptionist for current affiliations.) Furthermore, I acknowledge that not all plans cover certain procedures, lab tests or preventive health exams. I will be responsible for payment of these services.

I acknowledge & agree to pay for services at the time they are delivered. I also agree to pay co-payments, deductible and coinsurance amounts not paid by my insurance, at the time of service.

Signature \_\_\_\_\_ Date \_\_\_\_\_