BEE CAVES MEDICAL

PATIENT INFORMATION ***(PLEASE PRINT CLEARLY)***

Last Name ____________ First Name ____________ MI ______

Address ____________ City ____________ ST ______ Zip ______

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Social Security # ____________ Drivers License # ____________

Date of Birth ____________ Marital Status: S M D W Sex: M F

Emergency Contact: ____________ Phone # ____________ Relationship ____________

E-Mail Address: ____________

Employer: ____________ Address ____________

RESPONSIBLE PARTY (if different than patient)

Last Name ____________ First Name ____________ MI ______

Address: ____________ City ____________ ST ______ Zip ______

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Social Security # ____________ Drivers License # ____________ Date of Birth ____________

Employer: ____________ Address ____________

REASON FOR TODAY'S VISIT

Symptoms ____________ Date of onset ____________ Is this work related? Y N

If accident list details: What ____________ Where ____________

PAYMENT

Bee Caves Medical requires payment at time of service. Our average new patient charge is $100; your charge could be as high as $450 for the initial visit.

Method of Payment: Cash ______ Check ______ Credit Card ______

CONCERNING INSURANCE

Bee Caves Medical accepts assignment of benefits from insurance companies with which we are contracted as a participating provider.

BEE CAVES MEDICAL DOES NOT ACCEPT MEDICARE OR MEDICAID

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any remaining balance. I also authorize Bee Caves Medical or my insurance company to release any information required to process my claim.

X ____________________ ____________

Patient / Legal Guardian's Signature **Date**