SURGICAL ASSOCIATES OF AUSTIN

Chart # ____________

SMITH CHERICO MARKUS MAYER FLEMING ASHWORTH CHING SANKAR

Last Name ____________ First Name ____________ Middle ____________

Home Address ____________ City ____________

State ______ Zip Code ______ Home Ph. ____________ Cell ____________

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

E-Mail Address ____________ Can we contact you via e-mail: Y N

Employer Name ____________ Work Ph. ____________

Employer Address ____________ City ____________ State ______ Zip ______

DATE CONDITION BEGAN ____________ REFERRING DOCTOR ____________

Name of Primary Physician ____________

IF STUDENT, what is status: Full Part If minor, what is Guardian name ____________
(Guardian must complete all employer information and insurance information)

WORK RELATED: Yes / No If yes, date of injury
(If work related, the employment information above and the insurance information below must be completed to process your claim.)

In case of emergency, notify ____________ Tel. ____________ Relationship ____________

PRIMARY INSURANCE HMO PPO OTHER Specialist Copay ______

Insurance Name ____________ Address ____________

Member Name ____________ ID # ____________ Group # ____________

Policyholder (if other than patient) ____________ Date of Birth ____________

Social Security of policyholder ____________ Relationship to patient ____________

SECONDARY INSURANCE HMO PPO OTHER Specialist Copay ______

Insurance Name ____________ Address ____________

Member Name ____________ ID # ____________ Group # ____________

Policyholder (if other than patient) ____________ Date of Birth ____________

Social Security of policyholder ____________ Relationship to patient ____________

I understand that I am responsible for payment of all charges incurred by me. I authorize release of any of my medical information necessary to process claims to my insurance company. I also authorize payment of any assigned benefits to SURGICAL ASSOCIATES OF AUSTIN.

Signature ____________ DATE ____________