

Balcones Woods Family Medicine

First Name: _____ Middle Name: _____ Last Name: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Social Security # _____ - _____ - _____ Male Female Date of Birth: ____/____/____ Age: _____

Race: African-American/Black Asian White Other: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Preferred language: _____

Preferred pharmacy (See our list of codes. For example: Randalls at Research Blvd. and Braker Ln. is "R9") Code: _____

Employer: _____ Occupation: _____

Marital Status: Single Married Separated Widowed Divorced Living w/Significant Other

Spouse/Partner/Significant Other's Name: _____

Emergency Contact: _____ Relationship: _____ Phone Number(s): _____

Insurance Company: _____ Policyholder: _____

Relationship to Policyholder: _____ Policyholder's Date of Birth: ____/____/____ Policyholder's SS#: _____ - _____ - _____

I, the undersigned, certify that I (or my dependant) have insurance coverage with _____ and assign directly to Balcones Woods Family Medicine, all insurance benefits, if any, otherwise payable to me for services rendered.

If I am a Medicare patient, I understand that Balcones Woods Family Medicine does not accept assignment and that I am responsible for paying at checkout for services rendered, and that Medicare will pay me back directly.

I understand that I am financially responsible for all charges incurred. I hereby authorize Balcones Woods Family Medicine to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date: _____