PATIENT INFORMATION

695 Hill Country Drive, Suite C *
Kerrville, TX 78028 *
(830) 895-4466 * (830) 895-4465 Fax

Patient's Name (Last, First, Middle): _____

Mailing Address _____ **City/State/Zip + 4 digits** _____

Street Address: _____ City/State/Zip + 4 digits: _____

Home Phone _____ **Cell Phone** _____ Work Phone _____

Date of Birth _____ Age _____ **Social Security #** _____

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Separated ___ Sex: Male ____ Female ____

Race: Amer. Indian ___ Asian___ Black/African Amer.___ Hispanic ____ White ___ Declined ____ Other Race_____

Occupation _____ Employer _____

PREFERRED PHARMACY: _____ E-mail Address: _____

If Minor Child: Guarantor's Name _____

Address _____ Phone: _____

In Case of Emergency Contact: _____ Phone: _____

Spouse's Name _____ Work Telephone ( ) _____

How did you hear about us? ____Current Patient ____Website _____Internet _____

Referral/Primary Physician _____

INSURANCE INFORMATION

PRIMARY Insurance Co. _____ Address _____

Policy/Subscriber ID _____ Group No _____

Policyholder's Name _____ **Date of Birth** _____

Policyholder's Social Security # _____Relationship to patient: Self __ Spouse __ Child __ Other __

SECONDARY Insurance Co. _____ Address _____

Policy/Subscriber ID _____ Group No _____

Policyholder's Name _____ **Date of Birth** _____

Policyholder's Social Security # _____Relationship to patient: Self __ Spouse __ Child __ Other __

PATIENT / RESPONSIBLE PARTY FINANCIAL POLICIES

RESPONSIBLE PARTY MUST SIGN (MUST BE AT LEAST 18 YEARS OF AGE)

That undersigned hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself and/or dependents. I further expressively agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted by myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Please remember that insurance is considered a method of reimbursing the doctor for services rendered, and not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and other insurance companies pay a percentage of the charge. It is my responsibility to pay any deductible amount, coinsurance, out of network %, and/or any other balance not paid by my insurance company.

I am acknowledging that I have received a copy of the "Patient / Responsible Party Financial Policies" for D. Clint Morris, Jr. M.D.

_____ _____

Signature of Patient or Responsible Party **Date**