Heart of Texas Family Medicine, P.A.

Russ Skinner, M.D.

PATIENT INFORMATION:

NAME_____________________________ AGE______MARITAL STATUS__________
ADDRESS___________________CITY________________STATE______ZIP_______
HOME PHONE_____________________WORK PHONE_______________________
DATE OF BIRTH______________SOCIAL SECURITY #_______________________
EMPLOYER____
PREFERRED PHARMACY____

SPOUSE (if married)/GUARANTOR INFORMATION (if patient under 18)**:**

NAME____
ADDRESS___________________CITY______________STATE_________ZIP______
HOME PHONE______________________WORK PHONE______________________
DATE OF BIRTH________________SOCIAL SECURITY #______________________

EMERGENCY CONTACT:

NAME: ________________________________RELATIONSHIP: _________________
HOME PHONE: ________________________WORK PHONE____________________

INSURANCE INFORMATION

PRIMARY INSURANCE____
SUBSCRIBER/INSURED____
I.D.#__________________GROUP #__________CO-PAY/PERCENTAGE__________

SECONDARY INSURANCE____
SUBSCRIBER/INSURED____
I.D.#__________________GROUP #___________CO-PAY/PERCENTAGE_________

I understand that I am responsible for all charges incurred for my care unless other arrangements have been made and that insurance is filed by Dr. Skinner's office as a courtesy only. I authorize the appropriate release of any necessary medical information, and authorize all unpaid insurance benefits be paid directly to Dr. Skinner. By signing below I consent to treatment.

PATIENT/GUARANTOR SIGNATURE: ____________________________________

DATE: ____