



**CapitalMedicalClinic**

*Serving Austin since 1934*

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Email: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M F Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ SS#: \_\_\_\_\_

Ethnicity:  African American  American Indian  Asian  Caucasian/White  Hawaiian  Hispanic/Latino  Other

Race (circle one):  White  Hispanic  Black or African American  Asian  Chinese  Filipino  Japanese  Multiracial  
 Other  American Indian or Alaska Native  Native Hawaiian or Other Pacific Islander  Native American  Patient Declined

Preferred Language: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Home# \_\_\_\_\_ Work# \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

Who referred you? (please circle) FAMILY FRIEND PHYSICIAN REFERRAL ADVERTISEMENT WEBSITE

Name of person or physician referring you: \_\_\_\_\_

**INSURANCE INFORMATION OF POLICY HOLDER**

Primary Insurance: \_\_\_\_\_ Address: \_\_\_\_\_ State/Zip: \_\_\_\_\_ Phone#: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Relationship: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Address: \_\_\_\_\_ State/Zip: \_\_\_\_\_ Phone#: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Patient Consent to Share Personal Health Information**

I hereby authorize Capital Medical Clinic to share my personal health information including financial information with named persons below until further written notice from me:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Capital Medical Clinic reserves the right to charge \$50.00 for any appointment cancelled without 24hr-advanced notice and there is a \$25.00 charge to your account for each returned check.**

**Assignment and Authorization of Benefits**

I hereby give authorization for payment of insurance benefits to be made directly to Capital Medical Clinic, LLP for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is as valid as the original.

**Acknowledgement of Review of Notice of Privacy Practices**

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

**Authorization for Voicemail Usage for PHI**

I hereby give permission to leave a message on my voicemail concerning my personal health information  (decline option)

**Authorization to obtain Pharmacy History**

I hereby authorize Capital Medical Clinic to obtain my Medication History from my pharmacy/pharmacies for the purpose of Continued Medical Treatment. This will help the physician to have a more current and complete list of medications to assist in efficiently caring for your medical needs.

Pharmacy Name and address: \_\_\_\_\_

Pharmacy Phone #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

(If filling in the information via a computer, please print the form and then sign it.)