Austin Medical Associates • 2911 Medical Arts St., Bldg. 10• Austin, TX 78705
Jerry D. Vandel, M.D. • Erica Burgett-FNP-BC • p 512.477.1405 • f 512.477.1220

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____

Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Country:** _____

Phone #1: _____ **Cell:** _____ **Date of Birth:** _____ **Age:** ____ **Sex:** _____

SS #: _____ **Marital Status: Single Married Divorced Widowed Partner**

Employer Name: _____ **Address:** _____ **Phone#:** _____

Full-time, Part-Time, Student, Retired (If retired, retirement date): _____

Who may we thank for your referral?: _____ **Pharmacy:** _____

RACE– check one [ ] Asian [ ] Native Hawaiian [ ] Pacific Islander [ ] African American [ ] Caucasian [ ] Hispanic [ ] Other Race [ ] Refused to Report
ETHNICITY– check one:[ ] Hispanic or Latin American [ ] Not Hispanic or Latin American [ ] Refused to Report
LANGUAGE – check one: [ ] English [ ] Indian (includes Hindi & Tamil) [ ] Spanish [ ] Russian [ ] Other

INSURANCE INFORMATION

Primary Insurance: _____ **Policy#:** _____ **Group#:** _____

Secondary/Supplemental Insurance: _____ **Policy#:** _____ **Group#:** _____

If the primary carrier of one of your insurance policies is NOT yourself, please supply us with the following information for that person, so we may properly file your insurance claim.

Please circle one: Does the primary insured carry your: primary insurance secondary insurance or both insurance policies ?

Last Name: _____ **First Name:** _____ **MI:** _____

Street Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **Country:** _____ **Phone #1:** _____

Phone #2: _____ **Date of Birth:** _____ **Sex:** ____ **SS#:** _____

Employer Name: _____

Your relationship to the insured?: Self, Spouse Other _____

EMERGENCY CONTACT:

Name: _____ **Relation:** _____ **Phone#:** _____

AUTHORIZATION: I hereby authorize Assignment of Benefits to Jerry Vandel, M.D. I also certify that I will be responsible for the payment of services provided but not covered. I also authorize the Clinic and Doctors to release Medical Records and other information to Insurance Companies.

I acknowledge that physicians do not accept assignment of benefits on all insurance companies. (Please check with the receptionist for current affiliations.) Furthermore, I acknowledge that not all plans cover certain procedures, lab tests or preventive health exams. I will be responsible for payment of these services. I acknowledge that Jerry D Vandel, M.D. and Erica Burgett-FNP-BC are not contracted with any Medicare Advantage Plans except Aetna MAP..

I acknowledge & agree to pay for services at the time they are delivered. I also agree to pay co-payments, deductible and coinsurance amounts not paid by my insurance, at the time of service.

I understand that to be compliant, Austin Medical Associates submits immunization data to Immtrac to meet Meaningful Use criteria.

By signing this I authorize Jerry D. Vandel, M.D. or Erica Burgett-FNP-BC to evaluate and treat me.

Signature _____ **Date** _____