



Patient Registration and Insurance Verification

4207 JAMES CASEY, STE.203

AUSTIN, TEXAS 78745

Phone: (512) 440-7894

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PHYSICIAN _____ ASSISTANT _____

SURGERY DATE _____ TIME _____ DURATION _____

PROCEDURE _____

DIAGNOSIS _____ 23 HOUR OBS _____

ANESTHESIA _____ GENERAL _____ MAC _____ LOCAL _____ BLOCK _____ CHOICE _____

SPECIAL INSTRUMENTATION: (e.g. C-ARM) _____

PATIENT NAME _____ DOB _____

ADDRESS _____

PHONE: HOME _____ WORK _____ CELL/OTHER _____

SS# _____ M _____ F _____

INSURANCE CO.(PRIMARY) _____ PHONE _____

SUBSCRIBER NAME _____ REL TO PATIENT _____

***PLEASE ATTACH A COPY OF INSURANCE CARD

INSURANCE CO.(SECONDARY) _____ PHONE _____

SUBSCRIBER NAME _____ REL TO PATIENT _____

***PLEASE ATTACH COPY OF CARD

WORKERS' COMP CARRIER _____ PHONE _____

DOI: _____ CLAIM # _____ ADJUSTER _____

EMPLOYER _____ ADDRESS _____

CITY _____ ZIP _____ EMPLOYER PHONE _____

AUTH # _____