



**LOCKHART FAMILY MEDICINE**

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Lockhart, Texas 78644

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**PATIENT INFORMATION** (Please Print)

PATIENT'S NAME		MARTIAL			BIRTHDATE + AGE		SEX		S.S. #		
		S	M	W	DIV			M	F		
MAILING ADDRESS		APT. #		CITY AND STATE				ZIP CODE		HOME PHONE NO.	
DRIVER'S LICENSE NUMBER		EMAIL ADDRESS				CELL PHONE NO.					
PATIENT'S EMPLOYER OR SCHOOL NAME		OCCUPATION				WORK PHONE NO.		EXT.			
EMPLOYER'S STREET ADDRESS		CITY AND STATE				ZIP CODE					
SPOUSE'S NAME		OCCUPATION (INDICATE IF STUDENT)				HOME PHONE NO.					
SPOUSE'S EMPLOYER		EMAIL ADDRESS				CELL PHONE NO.					
EMPLOYER'S STREET ADDRESS						WORK PHONE NO.		EXT.			
EMERGENCY CONTACT NAME		MAILING ADDRESS				HOME PHONE NO.					
RELATIONSHIP TO PATIENT		CELL PHONE NO.				WORK PHONE NO.		EXT.			

**DRUG ALLERGIES**

**RESPONSIBLE PARTY** Parent or Guardian of a minor (under 18 y/o dependent child)

1ST GUARDIAN'S NAME & RELATIONSHIP		OCCUPATION (INDICATE IF STUDENT)				HOME PHONE NO.					
MAILING ADDRESS		APT. #		CITY AND STATE		ZIP CODE		WORK PHONE NO.		EXT.	
1ST GUARDIAN'S EMPLOYER		SOCIAL SECURITY NO.		DRIVER'S LICENSE #		CELL PHONE NO.					
2ND GUARDIAN'S NAME & RELATIONSHIP		OCCUPATION (INDICATE IF STUDENT)				HOME PHONE NO.					
MAILING ADDRESS		APT. #		CITY AND STATE		ZIP CODE		WORK PHONE NO.		EXT.	
2ND GUARDIAN'S EMPLOYER		SOCIAL SECURITY NO.		DRIVER'S LICENSE #		CELL PHONE NO.					

**INSURANCE INFORMATION**

PRIMARY INSURANCE		EFFECTIVE DATE		NAME OF POL HOLDER		DATE OF BIRTH		ID#		/ GROUP	
POLICY HOLDER ADDRESS				CITY, STATE, ZIP				POLICY HOLDER PHONE NO.			
SECONDARY INSURANCE		EFFECTIVE DATE		NAME OF POL HOLDER		DATE OF BIRTH		ID#		/ GROUP	
POLICY HOLDER ADDRESS				CITY, STATE, ZIP				POLICY HOLDER PHONE NO.			

**CONSENT FOR MINORS OR DEPENDENT ADULTS**

THIS CONSENT REMAINS IN PLACE UNTIL REVOKED IN WRITING OR CHILD IS NO LONGER A MINOR  
Who may bring the child in for treatment or followup other than the legal parent?

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER	ADDRESS

CONSENT FOR MINORS

1. I hereby give my consent for Dr. B. Romanek/Dr. K. Wheeler to evaluate and treat the patient of this form.
2. I have been provided with the Privacy Practicers Notice for Dr. B. Romanek/Dr. K. Wheeler.
3. I understand that my personal health information will be used for the purpose of treatment, payment, and the coordination of the health care needs of the patient.

ASSIGNMENT OF INSURANCE BENEFITS

Payment is due at the time services are rendered. I understand that I am responsible for any health insurance deductibles, co-payments or coinsurance. I understand that should membership verification not indicate coverage, I agree to pay in full for services rendered. I agree that billing information and address information is correct as shown on the front of this document. I authorize payment of medical benefits to Dr. B. Romanek/Dr. K. Wheeler for services rendered.

We have contracted with several insurance plans in order to accommodate your needs. While we are happy to provide this service to you, it is impossible for us to know the individual provisions of every patient's plan. The policy book you have received when you signed up for your insurance outlines the specifics of your plan.

It is your responsibility to read and understand your plan's provisions. If you have questions about your insurance coverage, call your insurance company or employer for clarification prior to your appointment.

When you see us for each visit you must let us know what the guidelines for your insurance coverage are. For **example, if your plan requires you to use a specific lab or radiology facility, it is your responsibility to let us know which one.**

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or other information necessary to process this claim. Dr. B. Romanek/Dr. K. Wheeler recognizes that information regarding my health care is confidential. Unless I request otherwise, Dr. B. Romanek/Dr. K. Wheeler will only release my health care information as specified by state law. I understand that I have the right to obtain copies of my health care information for a fee.

I, \_\_\_\_\_ give my permission to Dr. B. Romanek/Dr. K. Wheeler and staff to release medical information contained in my medical file about myself to those indicated below.

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

AUTHORIZATION TO TREAT

I hereby authorize treatment by Barton Romanek, M.D. / Kimberly Wheeler, M.D. and his office staff.  
A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE AS VALID AS THE ORIGINAL.

I have read and understood these office policies and agree to accept the responsibilities as described.

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date