LOCKHART FAMILY MEDICINE

Barton J. Romanek, M.D.
Kimberly M. Wheeler, M.D.

1009 W. San Antonio • Lockhart, Texas 78644
Office: (512) 376-5247 • Fax: (512) 376-6252
www.lockhartfamilymedicine.com

PATIENT INFORMATION (Please Print)

PATIENT'S NAME	Marital S M W Div	BIRTHDATE & AGE	GENDER M F	S.S. #
MAILING ADDRESS APT. #	CITY AND STATE		ZIP	HOME PHONE NO.
DRIVER'S LICENSE NUMBER	EMAIL ADDRESS			
RACE / ETHNICITY	PREFERRED LANGUAGE			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	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	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 Lockhart Family Medicine to evaluate and treat the patient of this form.
2. I have been provided with the Privacy Practicers Notice for Lockhart Family Medicine.
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 Lockhart Family Medicine 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. Lockhart Family Medicine recognizes that information regarding my health care is confidential. Unless I request otherwise, Lockhart Family Medicine 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 Lockhart Family Medicine 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 Lockhart Family Medicine and the 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.

_____ _____