

NAME _____ AGE _____ SEX _____
FIRST MIDDLE LAST

HOME MAILING ADDRESS _____
CITY STATE ZIP

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

WORK ADDRESS _____

SPOUSE'S NAME _____ ANY FAMILY MEMBERS SEEN HERE BEFORE? _____

EMERGENCY CONTACT PERSON AND PHONE # _____

NAME OF PRIMARY INSURANCE _____
(Please have your insurance card available for photocopying)

YOUR RELATIONSHIP TO POLICY HOLDER _____ SELF _____ SPOUSE** _____ CHILD**

**POLICY HOLDER'S NAME _____

**POLICY HOLDER'S SSN _____ & DOB _____

NAME OF SECONDARY INSURANCE _____

MEDICAL CONDITIONS, DISABILITIES OR CURRENT ILLNESSES _____

LIST ALL MEDICATIONS PRESENTLY BEING TAKEN _____

LIST ALL DRUG ALLERGIES (INCLUDE SKIN MEDS) _____

DO YOU HAVE ANY KNOWN RISK FACTORS FOR HIV? NO / YES – IF YES, EXPLAIN _____

DO YOU HAVE A HISTORY OF HEPATITIS? NO / YES – IF YES, EXPLAIN _____

REFERRED BY _____

DO WE HAVE PERMISSION TO LEAVE A MESSAGE ON YOUR ANSWER MACHINE? HOME-NO / YES WORK-NO / YES

NAME & RELATIONSHIP OF PERSON WE MAY RELEASE YOUR PERSONAL MEDICAL INFORMATION TO _____

HOW DO YOU WISH TO BE ADDRESSED BY OUR STAFF? _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I GRANT CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO WILLIAM M. RAMSDELL, M.D. FOR SERVICES RENDERED. I, KNOWING THAT I AM SUFFERING FROM A CONDITION REQUIRING DIAGNOSTIC, MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH PROCEDURES AND CARE AND TO SUCH MEDICAL, SURGICAL OR OTHER SERVICES UNDER THE GENERAL AND SPECIFIC INSTRUCTIONS OF WILLIAM M. RAMSDELL, M.D., HIS ASSOCIATES, OR HIS DESIGNEE AS IS NECESSARY IN HIS JUDGEMENT. I UNDERSTAND THAT I MAY BE SEEN BY A CERTIFIED PHYSICIAN ASSISTANT. I ALSO ACKNOWLEDGE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF EXAMINATION OR TREATMENT BY DR. RAMSDELL, HIS ASSOCIATES, OR HIS DESIGNEE.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ DATE _____

WILLIAM M. RAMSDELL, M.D. 102 WESTLAKE DRIVE, STE 100 AUSTIN, TEXAS 78746