

C. Ron Byrd, MD, PA
2712 Bee Caves Road, Suite 122, Austin, TX 78746 512/328-2752
Patient Information Record
(Please print information)

Patient name: _____
Last First Middle

Address: _____
Street Apt. City State Zip

Phone: _____
Home Work Cell

Date of Birth ____/____/____ Sex: M F Marital Status: Married Single Other

Social Security # ____-____-____ Driver's License # _____

Employer Name (or School) _____ Occupation: _____

Spouse/Parent Name: _____ Work Phone _____ Home Phone _____

Who referred you? _____

INSURANCE POLICY HOLDER

Patients are required to present proof of insurance coverage prior to services.
Otherwise, patient will be responsible for full payment of services at the time of the visit.

Name (if different from patient) _____

Address _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____

Social Security # ____-____-____ Date of Birth _____

Local Person to Notify in Case of Emergency

Name _____ Home Phone _____ Work Phone _____

City: _____ Relationship to patient _____

MEDICAL CARE: I authorize the physicians of **C. Ron Byrd, MD, PA** or their designees to provide myself or my child with reasonable and proper medical care according to today's standards

MEDICAL INFORMATION: I authorize the physicians of this office to release any information they have acquired in the course of my treatment or of my child's treatment to my insurance company or companies or any third party payor so that they may obtain payment for medical services rendered.

INSURANCE AUTHORIZATION: I hereby authorize the physicians or staff of this office to furnish information to my insurance carrier(s) concerning myself or my child's illness or treatments.

ASSIGNMENT OF BENEFITS: I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim.

I agree that I am financially responsible for the account even though Insurance may be pending on all or a portion of the charges.

Signature of Patient or Parent/Guardian _____ **Date** _____