SAXUM
MEDICAL SERVICES

PATIENT INFORMATION (Please Print)

First Name Initial Last Name				Sex at Birth	Marital Status	Social Security No. - -
Street Address			City		State	Zip Code
Driver's License No.	Date of Birth / /	Age	Cell Phone ( ) -	Home Phone ( ) -		Work Phone ( ) -
e-mail Address:						

Guarantor Information (if different from above)

Guarantor's Name					
Street Address		City		State	Zip Code
Driver's License No.	Date of Birth / /	Age	Social Security No. - -	Cell Phone ( ) -	Home Phone ( ) -

Insurance Carriers
Primary: Secondary:

Insurance Authorization and Assignment (PLEASE READ AND SIGN)

I hereby authorize Ruben J. Almanza, M.D., P.A. to furnish information to insurance carriers concerning my illness and treatments; and I hereby assign to the physician all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount that is not covered by the insurance. I hereby authorize photocopies of this form to be as valid as the original.

Signature	Relationship	Date / /

Emergency Contact Name	Relationship	Phone Number ( ) -

FINANCIAL STATEMENT	COPAYS, DEDUCTIBLES, AND ALL APPLICABLE FEES FOR PROFESSIONAL SERVICES ARE DUE AT THE TIME THAT SERVICES ARE RENDERED

HIPAA Privacy Notice Acknowledgement (PLEASE READ AND SIGN)

Please provide the names of people who can have access to your Protected Health Information.

1. 2. 3.

I have reviewed this office's Notice of Privacy Practices, which explain how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Signature	Relationship	Date / /

Communication Agreement

I hereby authorize Ruben J. Almanza, M.D., P.A. and its associates to leave messages on an answering machine or voicemail associated with the phone number(s) provided in this form:	Initial	Date / /

Preferred Local Pharmacy

Please enter your preferred local pharmacy:	Preferred pharmacy location

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