Patient Information Record

David T. Butler, M.D. Family Medicine (512) 258-5800

Patient Information

Last Name		**First Name**					**MI**		
Address							**Apt.#**		
City			**State**				**ZIP**		
Home Phone		**Work Phone**		**Ext**		**Cell Phone**			
Date of Birth		**Marital Status**		**Sex**		**SSN**			
Email									

Employer/School Information

Name		**Occupation**	
Address			**Ste.#**
City		**State**	**ZIP**

Insurance Policy Holder Information

Self If self, proceed to Emergency Contact	☐	**Spouse/Partner**	☐	**Parent**	☐

Last Name		**First Name**				**MI**	
Address						**Apt#**	
City			**State**			**Zip**	
Home Phone		**Work Phone**		**Ext**		**Cell Phone**	
Data of Birth						**SSN**	
Employer							
Address						**Ste.#**	
City			**State**			**ZIP**	

Emergency Contact

Name			**Relationship To Patient**				
Address						**Apt.#**	
City			**State**			**ZIP**	
Home Phone		**Work Phone**		**Ext**		**Cell Phone**	

Disclaimer

MEDICAL CARE: I authorize David T. Butler, M.D. or his designees to provide reasonable and proper medical care according to American Academy of Family Practice standards of care to myself or to my child.

MEDICAL INFORMATION: I authorize Dr. Butler to release any information he has acquired in the course of my treatment or my child's treatment to my insurance company(s) or any third party payer so that he may obtain payment for medical services rendered.

INSURANCE AUTHORIZATION: I hereby authorize Dr. Butler or his office staff to furnish information to my insurance carrier(s) concerning myself or my child's illness or treatments.

ASSIGNMENT OF BENEFITS: I authorize my insurance company or any third party payer to pay any benefits due directly to Dr. Butler should he accept assignment on my claim. I agree to be responsible for payment of any deductibles.

MISSED APPOINTMENTS: I am hereby notified that unless I give a 24 hours notice to cancel an appointment, there will be a $25.00 fee for a regular appointment and $45.00 fee for a physical appointment. I agree to pay the fee if I cancel my appointment in less than 24/48 hours or if I no-show without notice. I am aware that I will be asked to pay the fee with a credit card at the time of cancellation.

I agree that I am financially responsible for this account even though insurance may be pending on all or a portion of the charges. If no insurance is available, I will be responsible for full payment on the date of service.

Patient Signature		Date	