

C. Erik Anderson, M.D.



5103 Kyle Center Drive, Suite 104
(512) 268-8050
fax (512) 268-8056

Patient Registration Information

Today's Date _____

Name _____ Sex (circle) Male Female

Mailing Address _____

City/State/Zip code _____

Phone _____ Cell phone _____ Work phone _____

Date of Birth _____ SS# _____ Driver's License # _____

Your occupation _____

Employed by _____

Employer's Address _____

Family Physician _____

Referred by _____

Single _____ Married _____ Divorced _____ Other _____

Spouse's Name _____

Name, address & phone number of next of kin not living with you _____

Emergency Contact name and number _____

Insurance Information

Primary Insurance Company _____

Subscriber ID/Policy # _____ Group # _____

Policy Holder Name (last, first, middle) _____

Policy Holder Date of Birth _____ Policy Holder SS# _____

Relationship to patient _____ Phone # _____

Secondary Insurance Company (if applicable) _____

Subscriber ID/Policy # _____ Group # _____

Policy Holder Name (last, first, middle) _____

Policy Holder Date of Birth _____ Policy Holder SS# _____

Relationship to patient _____ Phone # _____

Worker's Comp: See workers comp form

Auto: See Auto Form

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Name _____ Date of Birth _____

Financial Disclosure and Medical Release

At Hays Surgical Associates we will do our best to collect payments from your insurance company. Please be aware that all insurance policies are different and you may be responsible for a co-payment, or percentage of your bill. Any questions with insurance should be addressed to your specific insurance company. We will accept most major credit cards, cash, and personal checks. If your personal check fails to pay due to insufficient funds, you will be responsible for additional costs for returned checks. Co-payments are payable at the time of service. At Hays Surgical Associates we are committed to meeting your medical needs. If you are unable to pay for services, we will be happy to work with you to set up a payment plan.

*****ATTENTION: Please Sign Below*****

If you do not sign, the responsibility for filing insurance and payment for bills will be YOURS
I authorize the release of any medical information that is in any way related to my physical or mental health status
which is in the possession of any other medical provider and may be requested in order to process this claim.

and

I authorize payment of medical benefits to Hays Surgical Associates. I also am aware that if my insurance company
does not cover services, or if Hays Surgical Associates does not accept assignment, I am responsible for all charges.

Print Name

Signature

Date

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Privacy Notice and Release of Medical Information

At Hays Surgical Associates, we are committed to insuring the privacy and confidentiality of your medical records. We comply with the Health Insurance Portability and Accessibility Act of 1996 (HIPAA)

- In order to assist us in protecting your privacy, please complete the following:

Patient name _____

My home phone number _____

My work phone number _____

My cell phone number _____

- Who may we speak with other than yourself regarding your medical care?

(If more than one, please list all)

spouse child brother/sister care giver friend other

Please list their name(s) _____

May we leave a message on your voicemail at home? yes no

May we leave a message on your voicemail at work? yes no

May we leave a message on your voicemail on your cell? yes no

May we mail medical information to your home? yes no

- When we make appointment confirmation calls and do not get an answer, may we leave you a voice message? yes no

I have been made aware of the privacy policies of Hays Surgical Associates, and have received (or been available to me) a copy of the Notice of Privacy Practices of Hays Surgical Associates.

Signature

Date

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Past Medical History

Date _____

Name _____ Date of Birth _____ Age _____

Reason for Visit _____

How and when did it start? _____

Past Medical History (check all that apply)

Anemia Diabetes Kidney Disease Seizures
 Arthritis/Gout Heart Disease Liver Disease/Jaundice Sleep Apnea
 Asthma/COPD High Blood Pressure Lung Disease Stomach Ulcers
 Cancer High Cholesterol Reactions to Anesthesia Stroke

Please List Any Other Major Medical Problems _____

Please List All Previous Surgeries and Date _____

Drug Allergies (please circle) None, Penicillin, Sulfa Drugs, Diagnostic Dyes, Aspirin, Iodine,
Codeine, Other _____

Do You Smoke? No Yes (how much and for how long?) _____

Do You Drink Alcohol? No Yes (how much and for how long?) _____

Marital Status: Single Married Divorced Separated Widow

Height _____ Weight _____

Do you feel safe at home? Yes No (explain) _____

