AUSTIN SURGEONS, P.L.L.C.

3901 Medical Parkway, Suite 200, Austin, Texas 78756

PATIENT CONTACT INFORMATION

1. ***Please list the family members or other persons, if any, whom we may inform/answer questions about general medical conditions and your diagnosis.***

Your Name:_____ Phone:_____

Spouse:_____ Phone:_____

Parent(s)_____ Phone:_____

Child(ren):_____ Phone:_____

Friend(s):_____ Phone:_____

Other:_____ Phone:_____

2. ***Please list the family members or significant other, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:***

Same as above: ☐ Spouse ☐ Parent(s) ☐ Child(ren) ☐ Friend(s) ☐ Other and/or list below: ☐

Name:_____ Phone:_____

3. ***Please print the address where you would like correspondence from our office to be sent, if other than your home address:***

☐ Same as Home Other:_____

4. ***Please print the number(s) where you want to receive calls about your appointments, lab and / or x-ray results, or other health care information.***

☐ Same as Home Cell:_____Work:_____

5. ***Please circle number(s) where we can leave messages:*** ☐ ***Home*** ☐ ***Work*** ☐ ***Cell***

6. ***Please list the pharmacy and phone number you would like your prescriptions called into.***

Pharmacy Name & Location:_____ Phone:_____

7. ***Do you have a living will?*** ☐ ***Yes*** ☐ ***No***
8. ***Do you have a Power Of Attorney?*** ☐ ***Yes*** ☐ ***No, If yes complete information below:***

Name of Person:_____ Phone:_____

9. ***I acknowledge receipt of the Notice of Privacy Practices:*** ☐ ***Yes*** ☐ ***No***
10. ***How did you learn about our office:***

☐ Referring Physician ☐ Our Web Site ☐ Print/Advertisement
☐ Friend / Family ☐ Insurance Web Site ☐ Other: List below

_____

Patient Signature _____ Date

~~~~ ALL INFORMATION IS STRICTLY CONFIDENTIAL ~~~~
~~~~