C. Ron Byrd, MD, PA
2765 Bee Caves Road, Suite 201, Austin, TX 78746 512/328-2752
Patient Information Record
(Please print information)

Patient name: _____
Last First Middle

Address: _____
Street Apt. City State Zip

Phone: _____
Primary Alternate Phone

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

Driver's License # _____

Email _____

Preferred Pharmacy _____ Location/Phone number _____

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: _____

Date of Birth of Policy Holder_____

Local Person to Notify in Case of Emergency

Name _____ Phone _____ Alternate 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.
PRESCRIPTION HISTORY: I authorize the physicians or staff of this office to view my prescription history from external sources.
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 _____